Money Follows the Person Rebalancing Demonstration Grant

Operational Protocol 2007–2011

State of North Carolina

Department of Health and Human Services

Grant No. 1LICMS030170

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North Carolina Department of Health and Human Services

Project Introduction

In May 2007, the Center for Medicare and Medicaid Services (CMS) awarded North Carolina a grant through Money Follows the Person Rebalancing Demonstration Program established by the Deficit Reduction Act of 2005. Services under this demonstration grant will end September 2011. North Carolina intends to use the funds to develop a roadmap for rebalancing Medicaid long-term care delivery system. Staff from state agencies, providers, advocates and consumers have worked together to create this road map for operations – the Money Follows the Person Operational Protocol.

The goal is to move forward with a long term care system that provides an even greater array of home and community-based services and supports designed to promote choice and independence for individuals who are aging with care needs, and/or have physical, mental, or developmental disabilities. The State intends to use Money Follows the Person funding to promote a long term care system in which individuals transitioning from nursing facilities and/or institutions have access to assistive technology, to increase the awareness and use of home and community based services through educational programs, and to offer more transitional services for individuals wishing to move back into the community.

Participants for Money Follows the Person are those who have lived in a institution for the mentally retarded (state and private facilities) or nursing facility for at least six months; meet Medicaid eligibility criteria; and meet the criteria for enrollment in one of the Community Alternatives Programs (CAP) waivers (CAP/MR-DD Comprehensive, CAP/Choice, and CAP/DA) or in the Program of All-Inclusive Care for the Elderly (PACE). CAP/Choice is currently being piloted in four counties (Cabarrus, Duplin, Forsyth, and Surry), therefore, when CAP/DA is referenced in this document it is understood that CAP/Choice applies as well. The State intends to transition 304 individuals for the identified population groups. Recipients will be enrolled in a CAP waiver or the Program of All-Inclusive Care for the Elderly (PACE) on day one of the move into the community. Participants will have a full array of services and supports for successful community living.

Money Follows the Person demonstration project will be available statewide with a five county exception: Cabarrus, Davidson, Rowan, Stanley, and Union counties. The Division of Medical Assistance has a 1915(c) waiver, Innovations, that operates concurrently with a 1915(b) waiver program, known as the Piedmont Cardinal Health Plan in this five county area. All Medicaid covered behavioral health and substance abuse services as well as Innovations waiver services for the MR/DD population are provided through the Piedmont plan. State staff will look at including these counties with the desire to have this option available by 2010. An amended Operational Protocol will be submitted once this is resolved.

As North Carolina progresses through the demonstration project, the following objectives will be met.

Objective 1: Increase the use of home and community-based, rather than institutional, long-term care services.

In 2004, the State Legislature passed House Bill 1414, section 10.12(a) mandating the Department of Health and Human Services, Division of Medial Assistance to develop a pilot program to implement the Program of All-Inclusive Care for the Elderly. This is a community based program that provides unique managed care benefits for the frail elderly. The program operates an adult day health center and:

- Provides a comprehensive array of medical and social services at the center
- Arranges for all in-home and referral services that may be required by each enrollee, and
- Uses an interdisciplinary team to manage care and services for each enrollee.

The first PACE site was opened in Wilmington, North Carolina in February 2008. Currently there are four enrolled participants with an anticipated enrollment of four participants per month. Two future sites are planned for Burlington (Piedmont) and Fayetteville. The Piedmont location has completed and submitted an application to CMS and is in the process of applying for Adult Day Health Care certification. The Fayetteville site has received approval from the programs' Board of Directors to pursue developing the program. Both future sites are expected to enroll an average of four participants per month. To assist in increasing the use of home and community-based, long-term care services, PACE participants are eligible to be enrolled as Money Follows the Person participants.

Slots have been reserved in the CAP waivers (CAP/DA, CAP/MR-DD, and CAP/Choice) and the Program of All-Inclusive Care for the Elderly for Money Follows the Person participants. Plans are under way to increase services and supports for continued success in the effort to rebalance long-term care and supports in North Carolina via waiver amendments and renewals. In addition to traditional CAP services, participants will have the opportunity to self-direct their own services and supports through a relatively new current waiver – CAP/Choice.

Objective 2: Eliminate barriers or mechanisms, whether in the State law, the State Medicaid plan, the State budget, or otherwise, which prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice.

North Carolina has worked in several areas to promote increased access to home and community based services. These include changes in services, additional waiver slots, partnerships with other agencies, service rate increases, nursing home transition efforts and program expansions.

In addition to services already offered under the three North Carolina's 1915(c) waivers (CAP/DA, CAP/MR-DD, and CAP/Choice) and the Program of All-Inclusive Care for the Elderly, Money Follows the Person will make services available to ease the transition when individuals move back into the community. Some of these are one-time occurrences, such as security deposits or home furnishings; the use of assistive technology has been expanded to include security devices and reminder systems and devices; and increased awareness and use of

home and community based services through education programs to the state's medical community.

North Carolina legislature has proposed in their fiscal year 2009 budget the allocation of additional funding to the Area Resource Center of North Carolina to provide housing to individuals with developmental disabilities. Also, additional targeted rental units, within the Housing Credit properties and smaller scale supportive housing developments are becoming available to assist Money Follows the Person participants who can live independently and/or with in-home assistance transition into independent rental housing.

Objective 3: Increase the ability of the State Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institution to a community setting.

North Carolina has experienced success with transitioning individuals from nursing facilities. In September of 2002, CMS awarded North Carolina Division of Medical Assistance a three-year grant of $600,000 to develop and conduct a **North Carolina Nursing Facility Transitions Program** in collaboration with North Carolina Division of Vocational Rehabilitation Services Independent Living Rehabilitation Program. In July of 2005, CMS approved a six-month no cost extension that extended grant-funded activities through March 29, 2006. By March 2006 (end of program), 134 individuals have been fully transitioned from nursing facilities to community living as a direct result of intervention managed, coordinated, and funded under this grant. The average length of time transitioned individuals remained in the community was 287 days at the time program evaluation data was reported.

The grant enabled North Carolina to demonstrate a successful collaboration between state agencies, regional non-profit organizations, and local agencies and groups. In particular, the North Carolina Division of Vocational Rehabilitation's Independent Living Rehabilitation Program and the Centers for Independent Living played key roles in identifying individuals for transition. Long-term care ombudsmen were also effective in identifying and referring nursing home residents interested in transitioning to community care. The agencies and organizations are committed to participating in these transition activities under the Money Follows the Person Demonstration.

North Carolina Nursing Facility Transitions Program Participant Task Force made recommendations—through lessons learned—to the Assistant Secretary of Office of Long Term Care at the conclusion of the grant project.

- Sustaining the transition process. Generally, is was recommended to make nursing facility transitions a priority via funding avenues which would produce supports needed to consumers for successful community living.
- Eliminate Intuitional bias. This would involve education of stakeholders, increase education and outreach to hospitals, doctors, and the medical community about long term care community options, and implement Money Follows the Person grant. Additionally, it was recommended that the Governor of North Carolina reinstate the Protection Advocacy Agency as a private, non-profit entity, separate from the state government structure. This occurred through the organization of Disability Rights NC, a private non-

profit organization working to improve the lives of people with disabilities by protecting their rights.

- Improve affordable, accessible, integrated housing. The highlights of the recommendations were to support the CMS housing grant, seek ongoing funding for the Key Program, and increased publicity of the Low Income Housing Tax Credit and the State Housing Tax Credit.

Objective 4: Ensure strategies and procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community-based long term care services and to provide for continuous quality improvement in such services.

Since Money Follows the Person will be implemented parallel with the 1915c waivers and the Program of All-Inclusive Care for the Elderly (PACE), quality assurance protocols developed for each of the waivers will be the basis for the required quality assurance strategy. At this current time, two of the waivers are either being submitted as new waivers or renewals. CAP/MR-DD Comprehensive is a new waiver and is being submitted by July 2008. CAP/DA is a renewal waiver and is being submitted by September 2008. CAP/Choice is an approved waiver using 3.5 version and meets all CMS assurances. The PACE program is a three-way agreement between the program, the State, and CMS and is an approved program using the 3.4 version. Each new waiver or renewal is using the required 3.5 version and will include all assurances, risk management, 24-hour back up, and critical incident as required by Money Follows the Person.

While in the demonstration, and continuing after the demonstration, participants will have access to consumer supports, such as a Personal Emergency Response system, to reduce their risk of incidents and ensure their community living is one of success. The quality of services and supports will be monitored through a newly designed Quality Management Strategy. Standardizing quality measures across programs and populations is anticipated to strengthen service delivery and improve outcomes for consumers.

Through the above four objectives and benchmarks established specifically for North Carolina, the State will continue to increase and expand home and community-based service over institutionally-based services.

Case Studies

The following case studies are intended to show how North Carolina's Money Follows the Person demonstration program will work from the consumer's point of view.

Case Study for a Person with Developmental Disabilities

The Key Players:

Caroline: person using services

Caroline's Family:

1. Frank: Caroline's father
2. Bill: Caroline's brother
3. Wendy: Bill's wife

Transition Team:

1. Tammy: transition coordinator
2. Sara: developmental center staff member – Qualified Developmental Disabilities Professional
3. Sam: joint surveyor/self-advocate
4. Donna: Caroline's key direct support staff person in the developmental center
5. Allison: staff member from the local advocacy group that is working with Tammy to coordinate Caroline's transition process
6. Chris: Caroline's new case manager/support broker in Greenville
7. Marissa: manager at Caroline's new support agency in Greenville

Caroline, who is 40 years old, loves people, big dogs, and the East Carolina University Pirates. Her affiliation with the Pirate Nation runs deep; she grew up in Greenville, where ECU is located. As a little girl, she attended the local school during the week, went to Pirates football games on Saturdays, and attended First Baptist church on Sundays. Caroline's family still lives in Greenville.

Although Caroline has cerebral palsy, uses a wheelchair, and requires total physical assistance, she had a fairly typical life experience until her mother died in 1980, when Caroline was 12. Her father, Frank, tried to piece together support for Caroline so he could continue work at a boat production factory, but he still had to miss work (and lose income) regularly when assistants weren't available.

In 1980, the only state-funded support option available to Caroline and her family was institutional care at the Caswell Developmental Center, a state-run intermediate care facility for the mentally retarded, in Kinston, about one hour away from Greenville. As a result, Caroline's family doesn't get to visit her much. She has two younger brothers she was close to growing up, but she doesn't get to see them much anymore, and they miss her. Caroline has a baby niece she's never met, and she hasn't gone tailgating at a Pirates football game in over 27 years.

Like everyone, Caroline needs some support to think through major life decisions, but can largely make decisions on her own and communicates these decisions verbally. Because she has spent most of her life in the developmental center, Caroline sometimes needs "community"

concepts explained to her. She is her own guardian and the people who know her best don't think she needs anyone else in that role.

Participant Identification

Caroline learns about Money Follows the Person: Sara, Caroline's Qualified Developmental Disabilities Professional at the Caswell Developmental Center, and Sam, from the North Carolina Association of Self Advocates, had a joint conversation about Money Follows the Person with every person on Carolina's caseload, including Caroline and her guardian. Together, Sara and Sam told each person about this opportunity for people to receive supports in their hometowns, to reconnect with their families, to possibly get jobs, and to do the things they enjoyed (like going to Pirate football games!). Sara and Sam were sure to tell people that the transition wouldn't always be easy, and community-based supports would pose some new challenges, but that this project gave people in developmental centers more choices about where they lived.

Caroline's guardian had indicated an interest in community living for Caroline on a Community Options Interest Survey and had discussed this with Caroline. Caroline was thrilled about the chance to go back home to Greenville and reconnect with her family and childhood friends. Sara and Sam spent a couple of hours talking with Caroline about the Money Follows the Person project; they asked her if she wanted to participate. Caroline was thrilled about the chance to go back home to Greenville and reconnect with her family and childhood friends. After Sara and Sam spent a couple of hours talking with Caroline about the Money Follows the Person project, they asked her if she wanted to participate. The East Carolina Behavioral Health would determine if Caroline was eligible to participate in Money Follows the Person project. If deemed eligible, she would have a level of care review conducted by clinical staff of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and then receive a CAP/MR-DD waiver slot.

Caroline's father loved his daughter and trusted Sara and the other staff at the developmental center. After all, they had taken care of his daughter for almost 30 years. Yet, he was a little anxious about what it meant for Caroline to move back to Greenville. Would he be expected to make sure Caroline had the supports she needed by himself? He was 65 years old and was still working. Sara acknowledged his concern and noted that the community resources and supports available to Caroline in Greenville were significantly more available and stable than they had been in 1980. Sara and Caroline ended the conversation with Frank by reassuring him that his involvement in the process did not obligate him to anything and that he would be supporting his daughter's dream by participating in the planning process.

Prior to Transition

A critical person in the State's MFP Project was Tammy, the Project's Program Specialist. Tammy was a state employee whose primary office was in Raleigh. Tammy worked with transition coordinators from local advocacy groups to ensure each person's transition was successful. Tammy found it helpful to have up to 180 days of transition coordination – a supplemental service under Money Follows the Person – for clients Tammy was deeply invested

in the idea of people living in their home communities. She viewed her role as helping to ensure local transition coordinators effectively guided Caroline and her family through the transition process and served as matchmakers to the community-based services available, including case management services. She also understood that her first commitment was to Caroline and others transitioning under the Project and she would do everything she could to ensure people and their families received the information and support they needed throughout the transition process.

While her role in Caroline's life was temporary, Tammy understood how critically important it was. There are so many details and logistics associated with successfully transitioning people. Tammy also understood that a key part of her role was to build positive relationships with everyone involved. She understood that the success and stability of a person's community living experience largely rested on everyone's ability to work together and to trust each other. Tammy was well networked among the state's advocacy groups. Transition coordinators from these groups would manage the day-to-day logistics of transitioning Caroline and others out of the developmental centers. Though transition coordinators from these groups would work in tandem with Tammy, Tammy was ultimately responsible for the transition's success.

In Caroline's case, Allison from Family Advocacy-a local advocacy group in Greenville-would serve as Caroline's transition coordinator. Family Advocacy had significant experience in helping people with developmental disabilities transition out of developmental centers and back into local communities. In addition to coordinating the logistics of the transition, Allison would work with others in Caroline's life to ensure Caroline understood what was happening at every step and would take the lead on communicating information about the Project to her.

Tammy and Allison scheduled a Saturday visit at Caswell Developmental Center with Caroline and her family (father Frank and brother Bill—at Caroline's request) together. Tammy knew that she would not be directly participating in all of the logistics and meetings about Caroline's transition. However, because she was ultimately responsible for the transition's success, she felt it was really important to attend every person's first meeting. After the first meeting, Allison would take the lead on the coordination and logistical details and would talk with Tammy regularly to keep her updated on the progress of Caroline's transition.

This first meeting was critical as it gave everyone involved an opportunity to talk about some of the basic living arrangements Caroline wanted in Greenville and some of the supports she would require. Tammy and Allison understood that the state's service delivery system was complex and often confusing to service users and their families. At this first meeting, they all talked informally about Caroline's coming back to Greenville, where she might enjoy living, the kinds of supports she would need, what activities she would enjoy, and the potential timeline for making the transition. While additional people (like provider agency staff) would need to be brought in to fine tune the details of Caroline's support structure, it was important for Tammy and Allison to have a broad understanding of Caroline's support interests and needs to ensure that the transition process honored her basic preferences.

The First Meeting of Caroline's Crew

At the end of the meeting, Tammy and Allison asked Caroline if she wanted to move forward with the process. Caroline eagerly said yes. With the others as witnesses, Allison assisted

Caroline and her guardian in reviewing and signing the Informed Consent form. Tammy and Allison asked Caroline and others who else should be a part of the process. Caroline asked if Bill's wife, Wendy, could become part of her crew. Wendy had always talked "girl talk" with Caroline during their visits and Caroline trusted her. Bill agreed to ask Wendy to come to the next meeting.

At the end of the meeting, Tammy and Allison provided Caroline, Frank, and Bill with their contact information and with individual packets of information about the Money Follows the Person demonstration project. Allison also promised to send them a written summary of the meeting they just finished.

Connecting Caroline with Service Coordination/Case Management Services

After getting to know Caroline and her family a bit, Tammy and Allison knew their first priority was supporting Caroline through the process of selecting a long-term, community-based service coordination service. There were three qualified coordination services in the Greenville area.

While ideally, representatives of each agency and Caroline would visit individually, it sometimes was logistically difficult to make this happen. East Carolina Behavioral Health had recognized the logistical hurdle and organized a service coordination provider fair two times each month. This provided an opportunity for people coming into services for the first time, either through the Money Follows the Person demonstration project or other channels, to learn about the different service coordination agencies in order to make a more informed decision. Allison knew the dates of these fairs and worked with Sara to secure developmental center transportation to bring Caroline and a few others who were transitioning back to the East Carolina Behavioral Health region.

At the Service Coordination fair, Allison and Caroline listened to the presentations and asked questions that had emerged from their day-long conversation on Saturday. Allison was careful to ask questions she knew would be important to Caroline and Frank based on the comments from their meeting so that Caroline could make a fully informed decision.

After the fair, Allison, Caroline, and Donna (Caroline's direct support staff from the developmental center) talked over lunch about which agency Caroline preferred. Caroline really liked "Your Best Life" agency because the staff knew a lot about the local housing market and how to help consumers get their own homes. Allison assisted Caroline in completing a freedom of choice form and then submitted it on Caroline's behalf. A few days later, a representative from Your Best Life called Allison to confirm their services and to introduce Allison to Caroline's new service coordinator, Chris, pending Caroline's final approval, of course.

While Chris was now involved and assisting in the transition process, everyone was clear that for as long as Caroline was in the developmental center, Allison remained the point person for the transition process, and Tammy continued to assume ultimate responsibility for the transition's success. It was discussed that transition coordination could begin no sooner than 60 days prior to Caroline's anticipated move date – her first day in the community.

By working through joint phone calls and e-mails, Allison, Chris, and Sara arranged the next group conversation about Caroline's supports. Allison, Chris, and Caroline's family would spend another Saturday on the road to visit Caroline and her staff at the developmental center.

This day-long Saturday conversation covered a lot:

- Caroline and her family got to know Chris, Caroline's service coordinator.
- Allison facilitated a personal futures planning session that gave Caroline the opportunity to think about what she wanted in her life and be more specific about what kind of supports she would need. This session wasn't really about services, specifically, but rather a chance for everyone to understand what Caroline hoped to get out of her life.
- Chris facilitated the group's development of a preliminary service plan based on Caroline's life goals and service support needs. Chris was responsible for making sure this plan of care met all of the relevant system requirements and for submitting the plan to East Carolina Behavioral Health. Chris provided information about the different providers that could meet Caroline's support needs.
- They discussed which providers Caroline would like to interview and she decided that she wanted Chris, Donna, Allison, Frank, and Wendy to be there to interview the providers as well if they could.
- Allison made sure Caroline received information on abuse/neglect policies, cost-sharing requirements, her other personal responsibilities, the state's complaint process, and other materials. Sara agreed to assist Caroline in processing the documentation more thoughtfully after the meeting.
- Chris and Allison explained that once Caroline received CAP/MR-DD funding, her level of care would be re-evaluated annually, at least two months before the current year's service eligibility expired and future determinations would occur during her birth month.
- They also discussed what would happen if Caroline needed to re-enter the intermediate care facility for the mentally retarded for an unforeseen reason over the next year. Caroline understood that if she remained in the intermediate care facility for the mentally retarded for more than 6 months, she would have to go through the Money Follows the Person assessment and eligibility determination for community-based supports process again. She also understood that should she remain institutionalized for 31 days or longer, was able to return to the community under Money Follows the Person demonstration funding, she would not receive again the transitions services she first received to set up her house (such as couch, chair, etc.).

Through this conversation, it became evident what services and supports provided by the Project Caroline would need her first year. Because Caroline had lived in the developmental center most of her life, she had no furniture of her own. While her family was able to contribute a dining room table and a dresser, they were unable to provide anything else. Caroline and her crew decided to use transition services funds (covered as a demonstration service with a limit of $3000) to purchase a bed that would elevate at the head and foot to meet Caroline's circulatory needs; a second bed for her staff to use; an inexpensive couch and living room chair , some basic

kitchen utensils and some dishware. They understood that this "start up" funding would not be available after Caroline's first year in the Project.

They also knew they would likely need to access environmental modification funding under the waiver to ensure any apartment Caroline rented would have a roll-in shower that she required. They knew that community apartments often supported modifications beyond what was required by the Americans for Disabilities Act so long as someone else paid for them. By using waiver dollars to modify her rental unit, Caroline and her crew were also inadvertently expanding the accessible housing capacity in Greenville. Caroline would also be provided a personal care assistant for four hours daily to assist with daily activities such related to lack of mobility (example: showering, dressing, moving into and out of the wheelchair).

Identifying a Provider

Chris was able to assist Caroline in narrowing down the possible provider agencies to two that were able to meet her support interests and needs. Through joint conference calls and e-mails that Allison arranged, Chris organized an opportunity for Caroline, her family, and the others she had identified to meet with the two provider candidates.

Sara arranged transportation for Caroline and her staff to visit Greenville and meet with potential providers. Bill (Caroline's brother) was able to join Caroline, her staff, Tammy, and Chris in meeting with the two providers. Both providers were very aware of the Money Follows the Person demonstration project through provider networks and the state-published information they received in the mail and on the Web. During the visit with each provider, Caroline and her crew got to talk to members of the provider's management team and direct support staff and were able to visit others served by the organization.

Caroline's crew and the two organizations discussed the kind of living options each could provide based on Caroline's preferences. One organization, Community Support Options ("Options"), indicated they fully supported Caroline to live in her own home and would help her secure community-based accessible housing—but to make the money work, she would likely need a live-in companion or a roommate.

After the full day, Caroline decided she really liked Options because of the level of flexibility they would provide her in creating her own supports. Tammy, Chris, and the provider staff all talked to Caroline and her family about how sometimes funding limits service options, but Caroline really liked that Options made a commitment to "figure out good solutions" and supported Caroline's dream of living in her own home.

Transition to Community Life

Making the Transition: When Caroline selected Options, the organization's management team created budgets for several different support scenarios that would meet Caroline's needs and be financially viable. The Options manager, Marissa, met and became part of Caroline's crew, making several trips to visit Caroline at the center. Through these visits, Marissa was able to get

to know Caroline and observe firsthand what kind of supports she needed and what worked for her. Marissa took extensive notes.

Through regular conference calls and face-to-face meetings, Caroline and her crew began to shape the structure of her supports in Greenville. Topics discussed included

- Caroline's new home (a handicapped accessible apartment in a local complex);
- her potential roommate (another Options consumer whom Caroline met and liked);
- her staffing pattern, based on her scheduling preferences and personal interests (24/7 support, with Bill and Wendy helping Caroline go to church on Sundays, a volunteer job with dogs);
- her transportation (a wheelchair-accessible van); and
- her transition of her medical and financial services to Greenville

ECU's last home game was scheduled for the Saturday of Thanksgiving weekend. The apartment was ready. Caroline's staff was trained. And even though it was slightly ahead of schedule, Caroline's crew decided to do whatever it took to formalize the transition in time for the holiday and the last Pirates game of the season. The apartment manager agreed to prorate her living expenses for November. Caroline's family agreed that if Options could ensure that Caroline's overnight staff was available Thanksgiving night, Caroline would spend Thanksgiving with her family without paid support during the day.

On the Monday before Thanksgiving, Caroline's crew met one last time at the developmental center. The center had been her home for nearly 30 years and it was important to Caroline to stay in touch with some of the other residents and staff to whom she had been close. The center staff threw Caroline a party, and Tammy made sure that everyone had Caroline's new contact information and that Caroline had the contact information for those people she cared about.

Caroline's crew met for a final meeting with everyone: Sara, Donna, Allison, Tammy, Marissa, Caroline's family, and (of course) Caroline herself. They went through the final checklist that outlined the numerous details—both anticipated and unexpected—that had to be addressed before the transition could be complete. They tied up loose ends and officially transferred lead coordinator responsibilities from Tammy to Chris. Caroline's crew helped load up Caroline's things and, in an accessible van that Options had made available, brought Caroline home.

Caroline enjoyed her first home-cooked Thanksgiving meal in nearly 30 years and cheered her Pirates to victory in their final game of the season!

Fully Transitioned into a Home and Community-Based Program

Thanks to the hard work and continued involvement of Caroline's crew, she is thriving in her new life. While there have been some bumps in the road (one of Caroline's staff accepted a new position three weeks after Caroline moved back to Greenville!), Options has remained responsive to meeting Caroline's needs. Marissa arranged coverage, with Caroline's remaining staff pitching in, until she could identify a new candidate. Caroline met and approved the candidate and now Candace is a valued part of Caroline's staff.

For two months after Caroline moved back, Tammy and Allison continued to check in with Caroline about how things were going. Tammy, Allison and Chris worked together to make sure all of the loose ends around the transition were tied up before Tammy turned over responsibility to Chris. Chris is now Caroline's point person and visits her at least once a month. Since her services are still new, Chris works hard to visit Caroline a few times a month until she is fully settled.

Caroline and her Greenville crew meet every few months to debrief on what's working and to work on how to address challenges that have emerged. Chris organizes these meetings around Caroline's volunteer job at the Humane Society.

Caroline's staff also attends professional development opportunities that focus on the emerging needs of people who have transitioned back into their communities. These trainings are funded by the Money Follows the Person demonstration project. Community-building remains a key topic. While Caroline's transition process revealed a rich network of natural supports, it was recognized that many people transitioning back into their communities would need staff assistance to develop and sustain unpaid relationships.

All in all, Caroline's transition process back to her hometown was a success and can serve as an example to others of what is possible under the Money Follows the Person demonstration project.

Case Study for an Individual with a Physical Disability

The Key Players:

Greg: person using services

Caroline's Family:
1. Sharon: Greg's wife
2. Shawn: Greg's son

Transition Team:
1. Jose: transition specialist from Center for Independent Living
2. Edward: Money Follows the Person Program Specialist
3. Peter: Shady Lawn Social Worker
4. Sally: CAP case manager

Background

Greg is 30 years old and has been living at the Shady Lawn Nursing Home since February 2007. In October 2006 Greg was involved in a car accident and sustained a C-6 level spinal cord injury. Prior to the car accident Greg was living with his wife Sharon and son Shawn in their home in Durham, North Carolina. Greg worked as an electrical engineer for Duke Power. Following the accident his wife Sharon was not able to provide the level of support that Greg needed to live in their home.

Greg was transferred to the Shady Lawn Nursing home in February of 2007 after he was discharged from an inpatient rehabilitation program. Greg continued to receive outpatient physical and occupational therapy while living at Shady Lawn. Staff from Shady Lawn provided transportation to his appointments. Although Greg made a lot of progress in rehabilitation and regained much of his upper body strength, he had very limited use of his hands and was unable to transfer himself in and out of his wheelchair upon entering Shady Lawn. He also needed some level of assistance with most daily living skills.

Process of participant identification

In February of 2009 Greg had been living at Shady Lawn for 2 years. Although Sharon and Shawn consistently came by for visits weekly, he missed seeing them on a regular basis and felt he was missing major milestones in his son's life. Greg located the number to his local Center for Independent Living (CIL) while doing research online. Greg called the Alliance of Disability Advocates Center for Independent Living and spoke with the transitions specialist, Jose, on staff.

Jose met with Greg at the Shady Lawn Nursing Home. The transition specialist spoke with Greg and briefly assessed the supports that Greg currently had available to him and the supports that

would need to be arranged in order for him to live with his family in the community. During their visit, Jose transition specialist told Greg about a new program called Money Follows the Person and explained how the project could help Greg transition to the community. Jose gave Greg some printed information about the Money Follows the Person project. He told Greg to share the information with his family and to decide if he and is family were ready to start thinking about creating a transition plan.

A week later Greg called Jose and indicated that he and his wife were ready to begin discussing a transition plan. Jose arranged a meeting with Greg, Sharon, Edward (Money Follows the Person Program Specialist), and Peter, a social worker from Shady Lawn.

Processes prior to the transition

At the meeting Edward explained the Money Follows the Person project to Greg and Sharon in more detail. Edward explained what service options could be available to Greg once he moved out of the nursing facility. The program specialist explained that the Community Alternative Program for Disabled Adults (CAP/DA) was a waiver program that allows people who are eligible for nursing facility care to receive supports in their home. It would be the best suited service package for Greg. The program specialist explained what services could be available through CAP/DA. The program specialist explained that some additional supports, such as one time transitions services, could be available to Greg though the Money Follows the Person demonstration grant. This would most likely be in the form of one time funding to help Greg secure needed items/support during the transition process. Greg expressed interest in moving forward in the transition process and creating a person centered plan and transition plan. The group scheduled another meeting to develop a person centered plan and transition plan for Greg.

Greg, Sharon, Jose, and Peter met two weeks later to assess discuss Greg's needs and give a clear picture of what Greg would need for successful living in his own home. They talked about the process Greg would go through: level of care assessment, needs assessment, person centered plan, and a transition plan. The group brainstormed a more thorough 'relocation' assessment to determine all of the supports that would be needed in order for Greg to successfully transition to living in the community:

- Personal data
- Professional care needs such as the continued need for physical therapy and occupational therapy
- Health care needs
- Mental health/counseling needs
- Housing preferences and any needed home modifications
- Family supports
- Available social networks
- Transportation needs
- Public and private supports needed
- Assistive technology needs
- What is important to Greg
- Greg's self-identified goals and plans for the future

The group also discussed that Greg would have a crisis plan as part of his community living. The plan would outline the need for back up staffing in the event that Greg's primary support staff is not available. It also included protocol for a variety of emergency situations.

Greg stated that he would like to move into the house that he and Sharon own once he left the nursing home. His home would need to be modified to make it wheelchair accessible. Greg said he thought he would need personal attendant services 3 hours each morning and evening to assist him with bathing, dressing, and other personal care tasks. Since Sharon currently works from home she would be available to help him prepare meals during the day. Edward assisted Greg in setting up an appointment with a CAP case manager at the Department of Social Services in Durham County.

Jose gave Greg contact information for accessible public transportation in Durham County. Since Greg's family does not currently own a wheelchair accessible vehicle he would need to utilize Durham Regional Transit Specialized Services to secure accessible transportation to his medical appointments. Greg and Sharon expressed interest in purchasing a wheelchair accessible van in the future but would need to save money in order to make such a purchase. Jose also put Greg in contact with another individual whom the Center had previously helped successfully transition out of a nursing facility. That individual was able to let Greg know exactly what the transition process would be like and provide peer support.

Processes during the actual transition into community life

Greg met with his new CAP case manager, Sally. Sally determined that Greg would be eligible for CAP/DA supports. Greg's doctor had completed an FL2 form indicating that Greg meets the requirement of needing nursing facility level of care. Sally indicated there would be no waiting period for a waiver slot. It was explained that the home modifications identified and written in his plan could be taken care of before he moved in. During this time period, Jose and Sally worked with Greg to ensure his house would ready for him to move in and to set up all of the necessary supports discussed in his transition plan. Jose worked with Greg to utilize the waiver funds to contract with a builder to construct a ramp leading to the front of Greg's house and to widen some of the doorways. The CAP/DA waiver services the team had a spending limit of $1,500/year. The transition specialist was able to locate a builder the Center had contracted with on other projects. He was able to provide services at a reduced rate. With help from his family and friends Greg was able to raise money to install a wheel-in shower in his downstairs bathroom. Greg's case manager worked to secure needed equipment such as a shower chair and hospital bed utilizing Medicaid funding.

Sally put Greg in contact with several agencies that provide CAP/DA services in Durham County. After Greg and Sharon called several agencies they picked the one that seemed to be the most receptive and reliable. This particular provider agency had a very detailed protocol for providing back up staffing in the event that a primary support staff was unavailable. The coordinator at the provider agency brought several potential support staff to Shady Lawn for Greg and Sharon to interview.

After two months Greg's CAP/DA services were in place, his primary support staff was selected, and his house modifications were completed. Greg, his wife, the Center for Independent Living transition specialist, the Money follows the Person program specialist, his case manager, the coordinator from the provider agency, and the nursing home social worker all worked together to ensure a seamless transition as outlined in Greg's transition plan.

CAP/DA services provided in-home aide 4 hours a day for Greg. Greg also requested a personal emergency response system through CAP/DA so that he would be able to quickly call for help in the event of an emergency or if his staff did not show up for his shift.

Processes when the individual has been transitioned into a home and community based program

Edward, Jose, Sally, and the coordinator from the provider agency met with Greg a week after his move to his house to ensure that the needed supports including his attendant services were in place and consistent.

Everyone from Greg's group continued to follow up with Greg after his transition to the community. They all remained in contact with Greg in various ways (phone, in-person, email) in some way on a month basis for six months following his transition. Edward and Jose would also check in with Greg and Sally over the phone regularly. They agreed that everyone would check in with Greg and one another over the phone and report updates to each other. The team worked together to address challenges that would come up as Greg adjusted to living at home.

Five months after Greg had transitioned to his house an incident occurred. Greg's wheelchair tipped over while he was at home alone. Luckily Greg had his personal emergency response system alert button around his neck. The emergency response center contacted Sally, Sharon, and the paramedics according to the protocol in Greg's crisis plan. By the time Greg's wife and case manager had arrived the paramedics were already there. Greg was taken to the hospital and it was determined that he had a broken arm. Due to the level of support Greg needed, it was decided by his team to have Greg enter the nursing home again, hopefully for less than 30 days. However, he had to stay 45 days in order to heal and receive physical therapy. Fortunately, he was able to re-enter Money Follows the Person project – all he needed to do was be determined that he meet CAP waiver requirements and he did. He was re-evaluated and his plan of care was updated. He had no changes in services and supports needed so he was able to continue on with the supports he had before the incident.

As it came near to the end of Greg's 365 days of demonstration services his team met again to look at the steps necessary to determine CAP eligibility so that his services would continue with no lapse. Greg's team worked together to ensure the assessments were completed prior to day 365.

Jose continued to remain in contact with Greg and his family following the 356 day period and provided independent living assistance as needed. When Greg expressed a desire to start working part time hours the Center for Independent Living transition specialist helped Greg contact Vocational Rehabilitation to begin receiving vocational services. The transition specialist also

put Greg in touch with the North Carolina Assistive Technology Center so that he could be assessed for voice input systems for his computer. Eventually Greg joined a support group of others in his area that had transitioned from a nursing facility to the community. With the group, Greg began to provide peer support to others that were going through the transition process.

Case Study for an Elderly Person

The Key Players:

Mrs. Sergor: person using services

Mrs. Sergor's Family:
Howard: Mrs. Sergor's husband

Transition Team:
1. Tommy: Regional Long-Term Care Ombudsman
2. Edward: Money Follows the Person Program Specialist
3. Patti: Transition Coordinator – Division of Vocational Rehabilitation
4. George: Nursing facility social worker
5. Michelle: CAP case manager

Background

Mrs. Sergor, age 65, has been residing in a New Hanover County nursing home for the past 10 months. Mrs. Sergor and her husband Howard moved to the coast of North Carolina from Charlotte when her husband retired eight years ago. Howard died suddenly a year and a half ago. She has no relatives living in North Carolina, but she has several friends from church who visit often. Due to her rheumatoid arthritis, Mrs. Sergor had a hip replacement at a Wilmington hospital and transferred to the nursing home for the expected two-week rehabilitation after her surgery. While she was there, she suffered a stroke, leaving her paralyzed on her left side. Mrs. Sergor received extensive rehabilitation and improved, but still needs assistance in bathing, dressing, and getting in and out of a bed or chair. Mrs. Sergor continues to need skilled-level care, but feels she is too young to be in a nursing facility. She was determined to be eligible for Medicaid three months ago.

Participant identification

The Regional Long-Term-Care Ombudsman – Tommy – was invited to speak to the resident council at the nursing facility. After the resident council meeting, Mrs. Sergor spoke with the Tommy about her desire to move out of the nursing home. Tommy had information for her regarding Money Follows the Person demonstration project. Tommy explained how the demonstration project assists individuals in long-term-care facilities to transition out of a nursing home and back into the community. Tommy explained that the funding was provided for 365 for an individual. So that individuals were not left without supports after 365 days, they were enrolled in CAP wavier program with additional supports under Money Follows the Person. Tommy gave Mrs. Sergor the telephone number for the Edward, Money Follows the Person Program Specialist, who is a State employee located in the Division of Medical Assistance in Raleigh. When Mrs. Sergor called the Edward, she was connected with the agency that serves as the transition coordinator in New Hanover County

Prior to the transition

The transition coordinator in New Hanover County – Patti, who is with the Division of Vocational Rehabilitation, Independent Living Section – scheduled an appointment to visit with Mrs. Sergor at the nursing facility. Patti explained the program in more detail and how the Money Follows the Person project could assist Mrs. Sergor in transitioning out of the nursing home into a place of her own. Patti explained the different living arrangements and service options available to her, including the Program of All-inclusive Care for the Elderly (PACE) or the Community Alternative Program for Disabled Adults (CAP/DA).

PACE is a managed care program in New Hanover County that enables elderly individuals who need nursing facility care to live as independently as possible. The PACE service package includes all Medicaid-covered services, as specified in the State's approved Medicaid plan, such as multidisciplinary assessment and treatment planning, social work services, skilled nursing care, primary care physician services, medical specialty services, specialized therapies, recreational therapy, personal care services, nutrition counseling, meals, medical supplies, home mobility aides, transportation, prescriptions, laboratory tests, rays, and other diagnostic procedures, durable medical equipment and corrective vision devices.

CAP/DA also provides services to adults who qualify for nursing facility care so they can remain in their private residences. The services include adult day health care; in-home aide services, level II and level III (includes personal care); supplies such as incontinence supplies, oral nutritional supplements, and medication dispensing boxes; case management, home mobility aids; adaptations to home environments (such as wheelchair ramps, safety rails, grab bars, non-skid surfaces, and so on and with a $1500/year limit); preparation and delivery of meals; respite care (both in-home and institutional); telephone alerts; and attendant care services,. Mrs. Sergor should be able to live independently after the transition with minimal risks if she participates in either the Program of All-Inclusive Care for the Elderly (PACE) or CAP/DA.

With Mrs. Sergor's approval, Patti arranged a meeting with Mrs. Sergor, George, and the director of nursing at the facility to review Mrs. Sergor's information from the Resident Assessment Instrument (RAI). That would help determine the medical support, personal care, and any other current supports needed to assist Mrs. Sergor in the community.

Patti began a detailed person-centered plan with Mrs. Sergor by discussing the roles of friends, housing options, health care, personal assistance, home adaptations or assistive technology, transportation, finances, her social and faith activities, and volunteer or employment options. Patti briefly explained the eligibility requirements for CAP/DA and the Program of All-Inclusive Care for the Elderly (PACE), and assisted Mrs. Sergor in setting up an appointment with the CAP case manager, Michelle, who would provide more detailed information. Michelle would work with Mrs. Sergor and any others Mrs. Sergor desired to develop a plan of care, which would outline the services and supports needed for a successful community living. The plan would include the supports Mrs. Sergor would have in the event of emergencies, such as a fall or no-show of her personal assistant. Michelle described the process for re-enrollment should Mrs. Sergor have to go back to the nursing facility. If she were to stay in the facility for longer than 30 days, she would be disenrolled. At the point she was ready for community living, she would

be re-evaluated and her plan of care would be updated to reflect the services and supports needed. Though they hoped this would not happen, it was explained to Mrs. Sergor that should she have three incidents of 30 days or longer in the nursing facility, she would no longer be considered for reentry into the project. With careful planning and strong supports, Mrs. Sergor and her team were planning on successful living and no re-entries into a nursing facility. Michelle explained to Mrs. Sergor that her supports under Money Follows the Person would continue after day 365, as she was enrolling in wavier services. She would have a redetermination of level of care each year, just before her birthday month. As long as she met the level of care required for waiver services, she would continue in the CAP/DA waiver program. This would mean no lapse of services for Mrs. Sergor after the 365 days of demonstration services.

Mrs. Sergor expressed a desire to move into a housing situation where two meals a day are provided. A senior congregate housing apartment complex in her former neighborhood is close to her church, and a few of her friends from church recently moved there. The rent is based on income so it is an affordable option. The apartment complex regularly transports tenants to the grocery store and shopping malls, and the housing manager would assist in arranging trips for medical appointments. Pattie assisted Mrs. Sergor in contacting the senior housing apartment complex to inquire about the availability of apartments.

Transition into community life

Patti met with Mrs. Sergor, George, and a close friend of Mrs. Sergor's to develop a plan to ensure the success of her transition. George is involved in the planning to ensure that the discharge for Mrs. Sergor is safe and orderly. Mrs. Sergor asked that her close friend sit in on the planning for emotional support.

Mrs. Sergor chose the service package with the CAP/DA. Typically, there is a waiting list for CAP/DA slots in the county; however, a person transitioning out of a nursing facility who is participating in the Money Follows the Person demonstration is given priority *and existing waiver slots have been reserved for MFP participants*. Mrs. Sergor spoke with the senior housing apartment manager and was informed an apartment would be available in a month. Case management services can be provided for up to 30 days prior to the first day of transition into the community and thirty days after, so this worked well that the apartment would be ready in 30 days. Over the next 30 days, Pattie and Michelle assisted Mrs. Sergor in securing essential furnishings for her new home (provided by demonstration funding), and also provided security deposits and connection fees for utilities through the Money Follows the Person one-time transition expenses. Mrs. Sergor was informed she had a $3000 limit on transition services, so she carefully considered what supports from this funding was most important to her success. Mrs. Sergor expressed a desire for a motorized wheelchair so she would have more mobility and be able to perform volunteer work at her church, which is across the street from her new home. With Mrs. Sergor's permission, Pattie contacted the Aging and Disability Resource Connection to obtain information about other community resources available to assist Mrs. Sergor in obtaining a motorized wheelchair.

The day arrived when her senior housing apartment became available and CAP/DA eligibility was approved. Patti worked closely with Mrs. Sergor and the facility George to ensure that her

discharge from the nursing home progressed in an orderly way. Patti ensured that Mrs. Sergor was able to find a doctor in the community, and that she had a sufficient supply of medications to last before her visit to her new doctor.

Transition into a Home- and Community-Based Program

Patti met Mrs. Sergor when she arrived at her new apartment, where her church had stocked the small kitchen with groceries afforded by the transition services funds from Money Follows the Person. Patti and the home health agency ensured that the in-home aide reported to work at the same time Mrs. Sergor moved into her new place. They gave Mrs. Sergor telephone numbers of Patti and the home health agency to contact directly if she has any problems or questions. Patti also provided Mrs. Sergor with the county department of social services contact information and information on how to report suspected abuse, neglect, or exploitation and reminded her again of the process for reporting critical incidents.

Patti told Mrs. Sergor she would check on her by phone or in person once a week for the next month to see how she was adjusting. The second month, Patti would visit her two times; and the third month, one time. The visits by Patti found Mrs. Sergor happy to be able to visit with her friends and enjoying participation in activities at the senior apartment complex and volunteering at her church.

One day, Mrs. Sergor had a challenge with her in-home aide, who provided her personal care services. The in-home aide failed to show up as scheduled. Mrs. Sergor tried to transfer herself to the wheelchair, but her arms were a little weaker than usual and she panicked. She remembered her emergency response button around her neck and pushed the button. The emergency response system alerted the home health agency and a neighbor who had a key. The neighbor went to the apartment and sat with Mrs. Sergor until the home health agency sent an in-home aide.

Benchmarks

The North Carolina Money Follows the Person Project will measure five benchmarks—two which are required by CMS and three developed by the State. Given the possible changing needs of the population and understanding that the benchmarks may need to be revised or edited once implementation starts, it is anticipated these could change. North Carolina will assess and provide revised benchmark information to CMS as needed.

1. ***The projected number of eligible individuals in each target group to be assisted in transitioning from an in-patient facility to a qualified residence during each fiscal year of the demonstration***

Projected number of transitioned participants by Federal Fiscal year and population						
	Elderly	**Physically Disabled**	**MR/DD**	**Mentally Ill**	**Dual Diagnosis[1]**	**Total**
2008	0	0	0	0	0	0
2009	5	47	20	0	0	72
2010	7	58	30	0	0	95
2011	10	97	30	0	0	137
Total	22	202	80	0	0	304

North Carolina has found it necessary to reduce the number of individuals transitioned from 552 to 304. This directive was given from staff at the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The following provides justification for the reduction in numbers:

1. **For MR/DD population:** A review of historical numbers of individuals who have transitioned from a Developmental Center to the community reflects that approximately half of those individuals chose to transition to community Intermediate Care-Mental Retardation facilities. This in part was due to the significant support needs of the individual. The developmental centers honor the choice of individuals and guardians in determining a community residential setting. These numbers also take into account the choice of individuals and their guardians. Based on this information, it is appropriate to reduce the targeted number of individuals transitioning to the community from State operated Developmental Centers. A survey of private Intermediate Care Facilities for the mentally retarded has since been conducted. Based on this information, the number of individuals to be transitioned has increased from 262 to 304.
2. **For Mentally Ill population:** The number of children in Psychiatric Residential Treatment Facilities (PRTFs) for over six months is limited and does not justify the original number of children targeted of 42.
3. **For Dual Diagnosis population:** The original intent of targeting this population group for Money Follows the Person was to transition individuals with Intellectual Developmental Disabilities/Mental Illness from state psychiatric hospitals to the community. Initially, consideration was not given to the fact that Money Follows the Person does not target non-Medicaid funded facilities such as Institutions of Mental Diseases where these individuals may reside.

[1] Estimated 35% of MR/DD/MI population will have dual diagnosis

While the above justification eliminates and/or reduces certain populations, it is the intent of the State to continue to consider further increases of the targeted populations, including the elderly. As the project progresses and if this is seen as a viable option, the State will amend its Operational Protocol with CMS to reflect such changes.

2. ***Qualified expenditures for Home and Community Based Services during each year of the demonstration program***

The increase in the numbers of home and community based services participants and expenditures are based on a comparison of state fiscal year 2005-06 and state fiscal year 2006-07. During that time expenditures rose over 77% and the number of unduplicated participants rose by 23%. There were also rate increases to some services over this period; therefore provider rate increases as well as participant increases are a factor in the total home and community based services expenditure over the five-year projected time period outlined in the benchmark above. The chart below reflects date of payment revenues in home and community based services. The CAP waiver expenditures include all home health and personal care services. Money Follows the Person will be transitioning the following number of participants into the following CAP waivers (day 1 of transition) through September 2011:

- 213 CAP/DA participants
- 80 CAP/MR-DD participants
- 6 PACE participants
- 5 CAP/Choice participants

Waiver	SFY 05-06 Actual Expenditures	SFY 06-07 Actual Expenditures	SFY 07-08 Forecast Expenditures	SFY 08-09 Forecast Expenditures	SYF 09-10 Forecast Expenditures	SFY 10-11 Forecast Expenditures
CAP/MR-DD	$285,774,984.00	$373,393,498.00	$373,470,551.50	$373,553,769.28	$373,667,808.46	$373,769,519.08
CAP/DA	265,616,823.00	$256,895,512.00	256,911,841.20	$257,015,939.85	$257,140,450.00	$257,297,618.55
CAP/Choice	$267,071.00	$591,344.00	$593,426.30	$595,508.60	$597,590.90	$599,671.20
PACE*	-	-	$89,370.54	$95,990.58	$102,610.62	$109,230.66
Total	$551,658,881.00	$630,880,654.00	$630,975,819.00	$631,165,217.73	$631,405,849.36	$631,666,808.83
% Increase in HCBS with 304 MFP Participants			1%	1.056%	1.752%	1.811%

*PACE began in calendar year 2008. At this time it is only available in one county.

The following additional benchmarks have been selected by the State:

3. Use of Assistive Technology

To promote a long term care system in which individuals at risk of transitioning from nursing homes have access to needed durable medical equipment, CAP/DA, and CAP/Choice are adding assistive technology as a service in future waiver renewals. CAP/MR-DD has within its current and future waiver, assistive technology already included. CAP/Choice and CAP/DA are up for renewal. The Departmental of Mental Health/Developmental Disabilities/Substance Abuse Services are currently developing a new Comprehensive CAP/MR-DD waiver.

Savings achieved as a result of the enhanced FMAP received by the Money Follows the Person demonstration will allows Money Follows the Person participants to receive newly purchased items and perform equipment repairs and general maintenance during the Money Follows the Person demonstration which will be sustainable after the Money Follows the Person demonstration ends.

Equipment - New
In 2006, North Carolina purchased 2,593 equipment items; in 2007, 903 items were purchased; and in 2008, 476 were purchased. In 2007 and prior, the Children's Special Health and Services (CSHS) program administered durable medical equipment for children. The drop in services from 2006 to 2007 was due to less client participation and imposed cost limitations when transferred to CAP/MR-DD waiver January 2008.

The projected number of items purchased, equipment rental and device demonstrations was determined by reviewing the Medicaid Management Information System claims data from the past three years, annualizing the data and determining a percentage based on the amount available for this Money Follows the Person demonstration rebalancing initiatives. Based on previous data, it is anticipated a 5% increase per year. This will result in monetary savings due to less need for nursing and in-home aid services.

The new equipment that will be purchased will range from low technology items such as adaptive utensils and transfer boards to high technology items such as speech generating devices, environmental controls. Under waiver renewals, the State will incorporate assistive technology devices ***not currently covered*** such as:

- security devices (example: remote keyless entry systems);
- reminder systems/devices (example: systems connected to the internet to announce reminders over an intercom system), and
- medication dispensing devices

These supports and services will be covered with FMAP during the demonstration period and afterwards with CAP waiver funds as appropriate.

	SFY2009	SFY2010	SFY2011
# of new items purchased	476	500	525

Equipment Repairs and General Maintenance
There is also research to support the need for equipment repairs and general maintenance. In 2006 - 2008, approximately 32 requests for equipment repairs were submitted. This supports the state need to include this service in its MFP demonstration grant. It is anticipated a 10% increase per year in equipment and wheel repairs. This includes ongoing maintenance such as battery replacement.

	SFY2009	SFY2010	SFY2011
# of new items repaired	9	10	11

#4. Increased delivery of educational programs regarding home and community based services to the State's medical community

The rebalancing of long term care expenditures will be accomplished by a number of different approaches that will take place simultaneously; for example, increased marketing of existing waiver services and conducting educational workshops for physicians and other medical personnel that would promote the use of home and community based services rather than the traditional move to a nursing or ICF/MR facility. In addition, encouraging and supporting, in collaboration with state healthcare associations and independent providers, the development and provision of training programs that would assist facilities to develop diversified services within their communities. These efforts would directly impact the goal of rebalancing between institutional and home and community based services expenditures as well as having a positive outcome of increased range of services available within the specific community.

The targets below are expressed as the number of in-person educational programs conducted for each provider category listed:

	Hospitals	**Medical Associations**	**Nursing/ICF Facilities**	**Senior Centers**
SFY 2008	0	0	0	0
SFY 2009	25	10	59	62
SFY 2010	25	10	59	62
FY 2011	26	10	59	64
Total	**76**	**30**	**177**	**188**

5. 85% of MFP participants will remain in the community for at least 1 year after transition with a 2% increase in subsequent years

Of the individuals who transitioned out of nursing facilities or intermediate care facilities for the mentally retarded as Money Follows the Person participants, 85% of these individuals will remain in the community for at least one year after transition. North Carolina anticipates a 2% increase each year thereafter. At the end of the demonstration at least 89% of all Money Follows the Person participants will remain in the community. The ultimate goal of the long term care rebalancing act is the rebalance elements of the state's long term care service system through a comprehensive approach that will address the complexities and inefficiencies of the current system, while improving consumer access to information and high quality, and appropriate services. The Money Follows the Person demonstration rebalancing initiatives will contribute to this goal by ensuring that individuals have the necessary supports and services to safely remain in their community.

The targets below are expressed as the number of persons who will remain in the community at least one year after they are transitioned out of a nursing home or intermediate care facilities for the mentally retarded:

	# Transitioned	**# Remained in Community**
SFY 2008	0	0
SFY 2009 (85%)	72	61
SFY 2010 (87%)	95	83
SFY 2011 (89%)	137	122
TOTAL	**304**	**266**

Participant Recruitment and Enrollment

Persons who are eligible for home and community based waiver services (CAP-MR/DD, CAP/DA, and CAP/Choice) and reside in an eligible institution will be eligible to participate in North Carolina's Money Follows the Person Demonstration grant. Individuals will transition into a CAP waiver program on the first day in the community. Slots have been reserved in each waiver program for Money Follows the Person participants. The following provides a description of the target populations within North Carolina that will be transitioned during the duration of the Money Follows the Person Demonstration Grant project, as well as the recruitment processes utilized for those target populations.

The target populations selected for transition include aging individuals with care needs and/or disabilities who have been residing in nursing facilities for a minimum of six months; individuals who have been diagnosed with a mental illness and who have resided in nursing facilities or special care units (for Alzheimer's or related disorders) for a minimum of six months and who are eligible for Medicaid 30 days prior to transition; individuals who have been residing in private Intermediate Care— Mental Retardation facilities or state-operated Intermediate Care Facility- Mental Retardation facilities (developmental centers) for a minimum of six months and who are eligible for Medicaid 30 days prior to transition.

Level of Care assessments will be completed on individuals according to the specific policies and procedures of the CAP waiver or Program of All-Inclusive Care for the Elderly (PACE) in which they are enrolling. Additionally, a detailed person–centered plan[2] (which includes a transition plan) is required to be completed for each individual who qualifies for transition through the Money Follows the Person Demonstration Grant project. Factors to be considered in the transition plan will include:

- Medical issues and resources to meet the identified needs
- Behavioral challenges and resources to address the needs including development of a behavior support plan with ongoing oversight and training by a licensed psychologist
- A clear, well documented crisis plan that addresses not only intervention techniques but the prevention processes as well
- Residential setting issues and assurances of appropriate staff and resources, including training of staff and/or family members/guardians and informal supports.

In all cases, the individual's family will be considered if the individual has provided permission for the family to be involved. Please refer to Marketing, Outreach, and Education section for additional information.

[2]The use of person–centered planning principles is being encouraged in all divisions within North Carolina Department of Health and Human Services for their day-to-day operations and use in policy development. Participation of agency's staff in developing these principles has truly been effective in helping the Department of Health and Human Services to make policy changes. This information was distributed in August 2007. It will take time for systems to change where this terminology is used consistently and across the board in all divisions. In the meantime, 'plan of care' will be seen in written documentation until such revisions and/or amendments are made. Specifically, within this document, both phrases will be seen and the reader is advised to understand there will be a gradual, systematic change to the use of 'person-centered planning' and the principles around this important concept.

In addition to the Money Follows the Person Project Director, a Money Follows the Person Program Specialist will be hired. The Program Specialist will be a State employee who oversees, coordinates, and manages the process of individuals from agencies assisting clients as they prepare for transition to the community. The Program Specialist will have experience and skills in transitioning individuals from facilities and institutions into the community and will be located in the Division of Medical Assistance office in Raleigh, North Carolina. The Program Specialist will serve as a resource in locating services, etc. Regional Ombudsmen from the North Carolina's Division of Vocational Rehabilitation Services—Independent Living will provide information regarding Money Follows the Person during mandated, quarterly visits to nursing facilities for those who express an interest in moving into the community.

Once an individual has been identified as a potential Money Follows the Person participant, the local lead agency or Local Management Entity or PACE organization will be contacted to begin the process of assessing, determining eligibility, and development of the plan of care/person-centered plan. In each community, staff and advocates from Centers for Independent Living, Division of Independent Living Rehabilitation Program, Association of Self Advocates, Real Advocates Now Emerging, and others will also work directly with individuals who express a desire to transition out of a facility.

Individuals who have Care Needs and/or Disabilities Residing in a Nursing Facility
To qualify for transition, individuals must have resided in the facility for a minimum of six months and be eligible for Medicaid 30 days prior to transition. The target region for this population is the entire state.

Individuals expressing a desire and interest to transition out of a nursing facility will review and discuss with their families/guardians and the transition coordinator, information from the Minimum Data Set or any other assessment tool used by the facility to determine medical support, personal care, and other supports available to the meet the individual's needs for transitioning to a qualified residence.

Transition coordinators will facilitate the process of identification through contact with the Regional Long Term Care Ombudsmen and/or Centers for Independent Living staff. The agency's transition coordinators will provide information to consumers and their families/guardians/caregivers to ensure an understanding of the Money Follows the Person Demonstration Grant project and the target population focus. This information will be provided in written and verbal form and will include information regarding the project itself, community residential options to nursing home placement, and support services available to maintain the individual within the community.

Individuals Who Are Residing in State-operated Intermediate Care–Mental Retardation Facilities (Developmental Centers)
Guardians of individuals residing in state-operated Intermediate Care–Mental Retardation facilities who previously indicated through a standardized survey (see **Attachment A**) an interest in their family member moving into community living will be provided information on Money Follows the Person Demonstration grant project. For individuals who have not had an opportunity to participate in this survey, community living options will be discussed at the

annual person-centered planning/plan of care meeting. The surveys were administered late 2007/early 2008 by developmental center staff. Throughout the demonstration project (2008-2011), as residents and guardians express a desire for community living, the survey may be administered.

Individuals Who Are Residing in Private Intermediate Care–Mental Retardation Facilities
A survey, similar to the one used in state-operated facilities, will be used in private Intermediate Care–Mental Retardation facilities to identify individuals desiring to move into the community from facilities (see Attachment B). Disability Rights North Carolina funded a pilot Volunteer Monitoring Project in Durham, North Carolina at which time individuals were identified who wanted to transition to the community. Development of a similar process is underway with the Money Follows the Person Project Director and advocates who administered the above mentioned survey. This process will be used state-wide in private Intermediate Care–Mental Retardation facilities.

Transition coordinators of local provider agencies will provide information to individuals surveyed and their guardians regarding Money Follows the Person Demonstration Grant project and their choice of community placement. This information will be provided in written and verbal form and will include information regarding the project itself and community residential options versus institutionalization, as well as services and supports available in the community that can be used so that the individual is able to remain within the community. Those individuals and their guardians (or family members with permission) who express an interest and desire to transition to the community will be the focus of the transition process during the first year of the demonstration (2008).

Qualified Institutional Settings

Individuals who have Care Needs and/or Disabilities Residing in a Nursing Facility
Qualified institutional settings include skilled nursing facilities and special care units (for Alzheimer's or related disorders) throughout the State.

Individuals Who Are Residing in Private or State-operated Intermediate Care–Mental Retardation Facilities (Developmental Centers - State-operated))
Qualified institutional settings include private Intermediate Care—Mental Retardation facilities and state-operated facilities (developmental centers) throughout the State.

Note: The short-term specialty programs at the developmental centers are exempt from the Money Follows the Person Demonstration Grant project.

Residency Requirements

Individuals who have Care Needs and/or Disabilities Residing in a Nursing Facility
The transition coordinator of local provider agencies will be responsible for ensuring, through contact with the administrator and staff of the facility, that the individual assessed for transition to the community has been residing in the nursing facility for at least six months. This will be documented via an admission summary.

Individuals Who Are Residing in Private or State-operated Intermediate Care–Mental Retardation Facilities (Developmental Centers - State-operated)
The transition coordinator of local provider agencies will be responsible for ensuring through the director and staff of the facility that the individual assessed to transition to the community has been residing in the developmental center or intermediate care facility for at least six months. This will be documented via an admission summary.

Process for Assuring Medicaid Eligibility

The transition coordinator will be responsible for ensuring that the individual who will be participating in the Money Follows the Person Demonstration Grant project continues to be eligible for Medicaid upon discharge from the facility. As applicable, hospital social workers, the developmental center's or Intermediate Care–Mental Retardation group home's reimbursement office and nursing facility discharge planners work in collaboration with the individual's local Department of Social Services in the specific county in which the individual resides to obtain documentation verifying Medicaid eligibility.

Enrollment
All individuals who wish to participate in the Money Follows the Person Demonstration Grant project, or if appropriate, the individual's legal guardian or representative, will be required to sign an Informed Consent (see **Attachment C**) indicating that they have freely chosen to participate, are aware of and understand the transition process, have full knowledge of the supports and services to be provided, and have been informed of their rights and responsibilities as participants. Additionally, participants and/or their family/guardian will be informed about the State's protections from abuse, neglect, and exploitation and the process for reporting critical incidents. A level of care assessment will be conducted and a plan of care/person-centered plan will be developed specific to the needs of each individual following the requirements of the waiver program which they are eligible.

Re-enrollment Policy
A Money Follows the Person participant who is re-institutionalized for a period *greater than 30 consecutive days* will be categorized as **disenrolled** from the program. However, a disenrolled individual may re-enroll in the program without re-establishing the six-month institutional residency requirements. As long as a former participant meets Medicaid waiver eligibility criteria, the participant will still be eligible for Money Follows the Person services at the enhanced Federal Medicaid Assistance Percentage match. However, if the former participant remains in the qualified institution beyond six months, the participant will be defined as a "new" Money Follows the Person participant in terms of the Money Follows the Person services and the Federal Medicaid Assistance Percentage.

A former participant may re-enroll in the program after being re-evaluated and after having an updated Plan of Care. Once the individual is assessed to be appropriate for home and community based services, a referral will be made to the case manager for development of the individualized Plan of Care that addresses any change in the status of the Money Follows the Person participant and/or any lack of necessary supports in the community. After three incidences of re-institutionalization of 30 consecutive days or longer, the re-institutionalized

Money Follows the Person participant will not be considered for reentry into the Money Follows the Person project.

Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility
In order to be considered for re-enrollment, an assessment must be completed to determine if adequate community resources are available to meet the medical needs of the individual. This will include verification by the transition coordinator of ongoing access to medical care specific to the needs of the individual.

Individuals Who Are Residing in Private Intermediate Care – Mental Retardation Facilities or State-operated Intermediate Care – Mental Retardation Facilities (Developmental Centers)
In order to be considered for re-enrollment, a detailed person-centered plan including a transition plan is required to be completed by a team of individuals consisting of developmental center staff, Local Management Entity staff, and community providers with specific processes to ensure community sustainability. [Person-centered planning tools such as Essential Lifestyle Planning or Making Action Plans may be used] Factors to be considered in the transition plan will include:

- medical issues and resources to meet the identified needs
- behavioral challenges and resources to address the needs including development of a behavior support plan with ongoing oversight and training by a licensed psychologist
- a clear and well documented crisis plan that addresses not only intervention techniques but prevention processes
- residential setting issues and assurances of appropriate staff and resources, including training of staff and/or family members and informal supports

Continuity of Care

Money Follows the Person participants will continue to receive waiver services at the end of the transition period (365 days) as long as they remain eligible for one of the waivers (CAP/DA, CAP/MR-DD, and CAP/Choice). If an individual does not continue to remain eligible for a CAP waiver, all efforts will be made to assist the individual and/or family/guardian in locating community services offered by various organizations and state programs in their local area. This will be explained to all individuals prior to enrollment into the Money Follows program and prior to transitioning out of the Money Follows the Person program.

Informed Consent and Guardianship

All individuals who wish to participate in the Money Follows the Person Demonstration Grant project (or, if appropriate, those individuals' legal guardians) will be required to sign an Informed Consent form (see **Attachment C**) indicating that they have freely chosen to participate, are aware of and understand the transition process, have full knowledge of the supports and services to be provided, and have been informed of their rights and responsibilities as participants. Additionally, participants and/or their family members and/or guardians will be informed about the State's protections from abuse, neglect, and exploitation and the process for reporting critical incidents.

Informed Consent

All individuals who want to participate in Money Follows the Person will be required to sign an informed consent stating they understand and agree to program requirements and have been informed of their rights, responsibilities, options and risks. This form will also indicate their willingness to participate in the Quality of Life surveys, which will be given two weeks before discharge, 11 months after discharge, and 24 months after discharge. All participants will acknowledge through the signed informed consent that they understand they will be reassessed for waiver eligibility prior to the end of 365 days. If an individual does not continue to remain eligible for one the CAP waivers (CAP/DA, CAP/MR-DD, and CAP/Choice), all efforts will be made to assist the individual and/or family/guardian in locating community services offered by various organizations and state programs in their local area.

Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility

Informed consent for participation in the Money Follows the Person Demonstration Grant project may be provided by the adult participant, emancipated minors, the parents of minors, or the legal representative or surrogate decision makers who have responsibility for individual's living arrangement, such as guardians, an attorney-in-fact named in a durable power of attorney, and a health care agent named in a health care power of attorney. In cases where there is a legal representative or surrogate decision maker, the transition coordinator will review appropriate legal documentation to ensure that the individual possesses the legal authority to make decisions dealing specifically with a participant's living arrangement and receipt of services/treatment.

Individuals Who Are Residing in Private Intermediate Care–Mental Retardation Facilities or State-operated Intermediate Care Facility-Mental Retardation Facilities (Developmental Centers)

Informed consent must be provided by the participant, unless that participant has been adjudicated as unable to make major life decisions. In that case, informed consent must be provided by the court-appointed guardian.

Guardianship

Chapter 35A of the North Carolina General Statutes contains the state's laws dealing with guardianship. In North Carolina, each of the state's 100 counties has a clerk of superior court who determines the appropriateness of guardianship and appoints a guardian if needed. Guardians are considered surrogate decision makers for individuals who may no longer be

capable of making and communicating decisions about themselves and/or their assets. The guardian's duty is to advocate for and assist the ward in exercising his or her rights.

A guardian may be an individual, such as a family member or friend; a corporation chartered to serve as guardian; or a disinterested public agent guardian. A disinterested public agent guardian may be the director or assistant director of a local human services agency (local Department of Social Services, Local Management Entity, local health department, or county department on aging) or an adult officer or agent of a state human services agency.

While North Carolina General Statute 35A does not specify the level of interaction between a ward and an individual or corporation serving as guardian, it does speak to the rights of the individual and the guardian/ward. Specifically, North Carolina General Statute 35A-1201(5) reads, "Guardianship should seek to preserve for the incompetent person the opportunity to exercise those rights that are within his comprehension and judgment, allowing for the possibility of error to the same degree as is allowed to persons who are not incompetent. To the maximum extent of his capabilities, an incompetent person should be permitted to participate as fully as possible in all decisions that will affect him." Additionally, North Carolina General Statute 35A-1241, Powers and duties of guardian of the person, (a)(2) states, "The guardian of the person may establish the ward's place of abode within or without this State. In arranging for a place of abode, the guardian of the person shall give preference to places within this State over places not in this State. The guardian also shall give preference to places that are not treatment facilities. If the only available and appropriate places of domicile are treatment facilities, the guardian shall give preference to community-based treatment facilities, such as group homes or nursing homes, over treatment facilities that are not community-based."

The General Statute also does not address how frequently a guardian must visit with a ward. Disinterested public agent guardians are required by North Carolina Administrative Code to have contact related to the ward no less than once every 90 days. Corporations and disinterested public agent guardians submit annual status reports to the clerk of court's office, detailing what has been done for the ward during a specified time period. These reports include the level of interaction between the guardian and the ward.

In regard to the Money Follows the Person Demonstration Grant project, legal representatives or surrogate decision makers who have responsibility for individual's living arrangement, such as guardians, an attorney-in-fact named in a durable power of attorney, and a health care agent appointed by the individual within the project, will be required and agree to have contact with the individual identified for transition within the last six months. Only a court-appointed guardian may act as guardian or other legally appointed representative for the participant. Corporations and legal guardians other than family members will follow their agency (such as local Department of Social Services or Local Management Entity) protocol for ensuring ongoing guardian interaction.

Case managers will work with guardians of Money Follows the Person participants to explain the program, safeguards and operating procedures. They will also work with the guardian and individual during the transition process so they fully understand their rights.

Training and Information

Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility

Each individual identified for transition to the community will be provided with information regarding protection from abuse, neglect, and exploitation and the process for notifying the appropriate authorities if the participant is subject to abuse, neglect, or exploitation. This information will be given by the transition coordinator to the individual as well as to other identified family members, legal guardians, etc., during the person-centered planning process. For details on abuse, neglect, and exploitation prevention and reporting, please refer to the Quality Management section.

Individuals Who Are Residing in Private Intermediate Care– Mental Retardation Facilities or State-operated Intermediate Care–Mental Retardation Facilities (Developmental Centers)

Each individual identified for transition to the community and, where applicable, his or her guardian or legal representative, will be provided with information regarding protection from abuse, neglect, and exploitation in the community and how to notify the appropriate authorities if the participant is subjected to abuse, neglect, or exploitation. The information will be reviewed with the individual and his or her guardian and/or legal representative by the individual's planning team during the person-centered planning process and at any time a transition meeting is taking place (should the desire to transition occurs prior to the annual person-centered planning process).

Processes for ensuring protection from abuse, neglect, and exploitation include the following. Transition coordinators, in collaboration with the Local Management Entity, will be responsible for training the individual and legal guardians in this system to respond to and report critical incidents and other processes.

- The North Carolina Administrative Code requires all Local Management Entities and provider agencies to participate in a Division of Mental Health/Developmental Disabilities/Substance Abuse Services coordinated system for responding to and reporting critical incidents and other life-endangering situations. This system addresses deaths, injuries, behavioral interventions (including physical restraints), and management of medications, allegations of abuse or neglect, and consumer behavior issues.
- Service providers are required to respond to all incidents by
    - ensuring the safety of consumers and others,
    - documenting the incident and steps taken to remedy the situation, and
    - analyzing incident trends as part of the agency's quality improvement process.
- Incidents are divided into three levels of severity, which determines the intensity and breadth of the response:
    - Level I include incidents that are already being addressed clinically and/or have limited immediate adverse consequences as isolated events, but that can signal the potential for more serious future problems if not addressed.
    - Level II includes incidents with immediate or potentially serious adverse consequences to the consumer or others, including such events as injuries, abuse allegations, and use of restrictive interventions.

    - Level III includes incidents with the most severe and permanent consequences—death or permanent impairment. In addition to the steps taken for all levels, within 24 hours providers must convene a team to address immediate needs regarding the safety and well-being of consumers, prevent continued or recurring damage from the event, and notify the consumer's guardian and the Local Management Entity of steps taken.
- Provider agencies handle level I incidents internally and make quarterly reports of aggregate numbers of level I incidents, identified trends, and activities being undertaken to address identified problems to the Local Management Entity.
- Provider agencies report level II incidents to the Local Management Entity within 72 hours. The Local Management Entity reviews these incidents to ensure that the provider is taking the necessary actions to keep consumers and others safe, to minimize the recurrence of the incident in the future, and to make the required reports to other authorities.
- When there is reason to believe that an individual has been abused, neglected, or exploited and is in need of protective services, the incident is also reported to the local Department of Social Services and to the State Health Care Personnel Registry for investigation. Criminal acts are also reported to legal authorities for investigation.
- Provider agencies report level III incidents to both the Local Management Entity and the Division of Mental Health/Developmental Disabilities/Substance Abuse Services within 72 hours (or immediately if a death occurred within 7 days of seclusion or restraint of the individual).
- Local Management Entities report information on level II and III incidents to the Division of Mental Health/Developmental Disabilities/Substance Abuse Services quarterly, including aggregate numbers of types of incidents, local trends identified in the Local Management Entity's analysis, and actions they have taken to prevent future incidents.
- The Division of Mental Health/Developmental Disabilities/Substance Abuse Services ensures that individuals receive support to exercise their rights and voice complaints. The Local Management Entity is the local hub for receiving complaints about service provision.
- In addition, per administrative rule, each area board for the Division of Mental Health/Developmental Disabilities/Substance Abuse Services or Local Management Entity services is required to operate at least one Client Rights Committee, and require contracted providers to operate a Client Rights Committee as well.
- North Carolina General Statute 122C-64 states that the Client Rights Committee is responsible for protection of client rights and includes provisions regarding confidentiality, right to treatment and consent to treatment, use of corporal punishment, use of physical restraints or seclusion, and protection from abuse and exploitation.
- The Local Management Entity Client Rights Committee reviews incidents and consumer complaints, including alleged violations of the rights of individuals or groups; cases of alleged abuse, neglect, or exploitation; concerns regarding the use of restrictive procedures; and failure to provide needed services that are available. The

Committee reviews incidents occurring within a contract agency after the governing body of the agency has reviewed the incident and has had opportunity to take action.

- The Committee makes recommendations to the Local Management Entity board and may report to the local Department of Social Services and other applicable licensing agencies, such as the Division of Health Services Regulation and the Division of Public Health.
- The Community Services Customer Rights team tracks and analyzes all complaints that come to the Division. Data collected on complaints include complainants and consumer information, the type of complaint, results of attempts to resolve the complaint, and the number of contacts.
- Locally mortality reviews are conducted by the Quality Improvement Committee of the Local Management Entity.
- The Performance Contract with Local Management Entities requires that Local Management Entities produce reports and use them for planning, decision making, and improvement. The reports shall analyze and summarize patterns and trends. Trends related to consumers include incidents and client rights. Local Management Entities must report quarterly all incidents and deaths as well as complaints as part of the Performance Contract with the Division of Mental Health/Developmental Disabilities/Substance Abuse Services.

Responsible Entities

Aging Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility

The transition coordinators, in collaboration with the local Department of Social Services adult protective service worker, will be responsible for providing the individual (and his or her legal guardian(s), if applicable) with local information regarding whom to contact and how to report suspected abuse, neglect, or exploitation and the process for reporting critical incidents. All Money Follows the Person participants in the CAP/DA and CAP/Choice waivers will receive information regarding protection from abuse, neglect, and exploitation and the process for notifying appropriate authorities when abuse, neglect or exploitation. This information and explanation occurs during the development of the person centered plan. This process is facilitated by the case manager.

Individuals Who Are Residing in Private Intermediate Care–Mental Retardation Facilities or State-operated Intermediate Care–Mental Retardation Facilities (Developmental Centers)

Transition coordinators, in collaboration with the Local Management Entity, will be responsible for providing the individual (and his or her legal guardian(s), if applicable) with local information regarding to whom to make protective services reports and the process for reporting critical incidents. All Money Follows the Person participants in the CAP/MR-DD Comprehensive waiver will receive information regarding protection from abuse, neglect, and exploitation and the process for notifying appropriate authorities when abuse, neglect or exploitation occurs. This information and explanation occurs during the development of the person centered plan. This process is facilitated by the case manager.

Outreach, Marketing, and Education

To support the successful implementation of the Money Follows the Person Demonstration Grant project, generic outreach and marketing materials will be developed to be used across a wide range of audiences and locations. A general information sheet template **(Attachment D)** will be available to all audiences. State staff may edit this template for use with specific audiences. Additionally, a flow chart template will be developed to explain the transition process. This template may also be edited to suit various audiences.

Participants

Participants in the Money Follows the Person Demonstration Grant project are those who have expressed an interest in transitioning and who wish to live and receive supports and services in the community of their choosing. Interest in transitioning would have been gained through the methods noted in Participant Participation and Enrollment. Information is disseminated to participants in several stages: pre-transition, post-transition, and ongoing. During the pre-transition stage, potential participants will be notified about the opportunity to transition to the community. During the three months after the transition and on an ongoing basis, participants will be notified of additional services and supports in the community. Participants, potential participants, and/or guardians will be kept informed of services available through the Money Follows the Person demonstration grant throughout the project.

Providers

Providers in the Money Follows the Person Demonstration Grant project are those public, private, and community organizations that will provide services and supports to the participants so that they are able to successfully transition to and remain in the community. There are a wide variety of providers with multiple interests. Many providers have already been notified of the Money Follows the Person Demonstration Grant project. A provider workgroup has been formed; its members have been involved in reviewing the protocol and will continue to be involved through the life of the project. A mass mailing will also be designed for providers to make them aware of the Money Follows the Person Demonstration Grant project and the opportunities for involvement. Examples of service providers across the state are

- Community providers of waiver services
- Professional caregivers
- Nursing home administrators
- Health care workers at agencies providing waiver services
- Community Mental Health Centers
- Centers for Independent Living
- Aging and Disability Resource Connections

During the public forums and stakeholder events being held for CAP waiver renewal information dissemination, the community at large will have the opportunity hear about Money Follows the Person demonstration grant benefits and services. During these meetings, which are planned for May 2008, Money Follows the Person staff will be available to present information and answer questions regarding the demonstration project.

Additionally, as noted in additional Benchmark #4, outreach will be conducted as a means of rebalancing of long term care expenditures. This will be accomplished by a number of different approaches that will take place simultaneously; for example, increased marketing of existing waiver services and conducting educational workshops for physicians and other medical personnel that would promote the use of home and community based services rather than the traditional move to a nursing or ICF/MR facility. In addition, encouraging and supporting, in collaboration with state healthcare associations and independent providers, the development and provision of training programs that would assist facilities to develop diversified services within their communities. These efforts would directly impact the goal of rebalancing between institutional and home and community based services expenditures as well as having a positive outcome of increased range of services available within the specific community. These programs will be conducted by Money Follows the Person staff and any other staff designated as knowledgeable about such services. A training packet will be developed as part of information dissemination.

State Staff

State staff refers to the employees of the North Carolina Department of Health and Human Services (Department of Health and Human Services) who will be involved in the Money Follows the Person Demonstration Grant project. A wide variety of staff and Department of Health and Human Services divisions are touched by this initiative. Examples of State agency divisions are

- Department of Health and Human Services
- Division of Medical Assistance
- Division of Aging and Adult Services
- Division of Vocational Rehabilitation Services
- Office of Long-Term Services and Supports
- Department of Health and Human Services—Office of Housing
- Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Other

Advocacy groups also serve as important audiences for Money Follows the Person Demonstration Grant project information. The Division of Medical Assistance will design a mass mailing, using postcards, to provide basic information about the Money Follows the Person Demonstration Grant project to various advocacy groups. Examples of advocacy groups across the state are

- North Carolina Council on Developmental Disabilities
- Centers for Independent Living
- disAbility Rights of North Carolina
- Carolina Legal Association
- Coalition on Aging
- Friends of Residents
- Health Care Faculties Association
- Home Care Association
- Long-Term-Care Regional Ombudsman
- Mental Health Consumers Association

- National Alliance on Mental Illness
- Real Advocates Now Emerging
- Association of Self Advocates

Types of Media to be Used

Participants

Participants may receive information on Money Follows the Person demonstration grant services via brochures, broadcast messages (television or radio), in-person-visits to nursing facilities and institutions, Medicaid card inserts, and the Division of Medical Assistance's website at http://www.ncmfp.com. Information will also be available on tapes, CDs, videos, and other formats. Media press releases may also be used.

Providers

Providers may receive information using the following media: Division of Medical Assistance bulletins (e-postings), Money Follows the Person Demonstration Grant project information sheet, Division of Medical Assistance website, remittance advice banner messages, verbal recordings that providers hear while on telephone hold with the Division of Medical Assistance, mass mailings (post cards) to provider associations, and inserts in conference "swag bags."

State Staff

State staff may receive information via the Division of Medical Assistance website, fact sheets, and training sessions.

Specific Populations to Be Targeted

Aging Individuals Who Have Care Needs and/or Disabilities and Who Reside in a Nursing Facility

Facilities throughout the state will be targeted through nursing facility transition coordinators with the Centers for Independent Living and the North Carolina Division of Vocational Rehabilitation Services Independent Living Rehabilitation Program.

Individuals Who Are Residing in Private or State-Operated Intermediate Care–Mental Retardation Facilities

Private Intermediate Care–Mental Retardation Facilities and state-operated facilities (developmental centers) throughout the state will be targeted.

Information Dissemination

The following resources will be used for information dissemination:

- Aging and Disability Resource Connections
- Various non-profit health care organizations, including
    - National Multiple Sclerosis Society
    - ARC of North Carolina
    - Easter Seals/UCP of North Carolina
    - National Alliance on Mental Illness
    - Mental Health Association
    - Provider associations
- Local management entities (including Community and Family Advisory Committees)

- North Carolina Family Resource Line
- Centers for Independent Living
- Rehabilitation centers
- Nursing facilities
- North Carolina Division of Vocational Rehabilitation Independent Living program offices
- Senior Health Insurance Information Program/North Carolina Senior Medicare Patrol
- Long-Term-Care Ombudsmen offices
- North Carolina Council on Developmental Disabilities
- Providers of Programs for All-inclusive Care for the Elderly (PACE)
- Lead agencies for the CAP/DA
- disAbility Rights North Carolina
- Local libraries
- Community spaces (example: Parks and Recreation centers)

Staff Training

Annual training for Money Follows the Person services will be provided for stakeholders. This would include those who assist in transitioning individuals, those working with CAP waiver services and benefits, information technology staff, and staff from agencies providing transition services. This training will be videotaped, and each person who participated in the training will also have a six-month refresher session/video update.

Other options for training include conference calls and Web-based training activities. These will be scheduled regularly and/or as needed.

Continuing Education Units should be offered to nursing facility staff, referring agencies, and others. This was demonstrated to be a successful technique during North Carolina's Nursing Home Transition grant.

Bilingual Materials/Interpretation Services

Materials will be available in English, Spanish, Braille, and large print. Electronic materials will be accessible to those who use screen readers.

Informing Eligible Individuals of Cost-Sharing Responsibilities

All materials intended for use by participants and their family, friends, and guardians will include language that indicates the responsibility of the individual to participate in cost sharing (deductible), if applicable.

Stakeholder Involvement

On September 17, 2007, a Money Follows the Person Project kick-off meeting was held to inform stakeholders and State staff about the project. This meeting gave an overview of the project; described the funders' (CMS) role; and provided information on how the Operational Protocol would be developed. Dates for Town Hall meetings were announced and participants were encouraged to attend to provide input into the development of the Operational Protocol and service delivery.

Stakeholders

Stakeholder involvement is acquired through various committees and workgroups. The Money Follows the Person Demonstration grant is overseen and administered by the Department of Health and Human Services. Leadership from the Department of Health and Human Services is represented on the **Executive Committee,** which sets policy and resolves issues. The **Stakeholders Advisory Group** helps structure the development and implementation of benefits and service deliveries of the Money Follows the Person Demonstration grant in ways that address the needs of stakeholders. Stakeholders are identified as consumers, families of consumers (which together comprise 60% of the membership), providers, and advocates of services provided through Money Follows the Person grant (which together comprise 40% of the membership). (See Consumer Involvement, below, for more detail.) The **State Workgroup** developed the Operational Protocol, implements the benefit package, and responds to the administrative requirement for the project. The **Demonstration Workgroups** are comprised of providers, consumers, advocates, and staff to provide specifics on system issues facing long-term-care services delivery and needed changes. See **Attachment E.**

The Money Follows the Person Stakeholder Advisory Group was formed in late March and has met two times – 4/2/08; phone conference 4/28/08 – to provide input into the Operational Protocol. It is anticipated this group will meet four to six times per year. Reimbursement is provided to committee members and their travel assistant (if applicable) in attending the meetings. This expense is reflected in the budget.

Consumer Involvement

Consumers, advocates, and others were invited to participate in six demonstration workgroups as a prerequisite to developing the Operational Protocol for the Money Follows the Person Demonstration Grant project. As the protocol was developed, the workgroups met a total of seven times and was provided with an opportunity to review and comment on the draft Operational Protocol. Group members were kept abreast of changes and developments in the Operational Protocol via email. Members responded with information and/or edits.

- Recruitment/Enrollment, Informed Consent Guardianship Workgroup met 10/9/07;
- Provider Workgroup met 10/12/07; phone conference was held 10/19/07
- Continuity of Care and Quality Workgroup met 10/11/07
- Benefits Workgroup met 10/10/07 and 10/15/07

Outreach Workgroup met 10/10/07

Four Town Hall meetings were held across the state to solicit input into the development, implementation, and evaluation of Money Follows the Person.

- Raleigh, North Carolina – 11/29/07
- Wilmington, North Carolina – 12/4/07
- Greenville, North Carolina – 12/5/07
- Hickory, North Carolina – 12/6/07

During the month of May 2008, Money Follows the Person staff participated in five of six Town Hall meetings for waiver renewals and presented information and received feedback on Money Follows the Person demonstration services:

- Goldsboro, North Carolina – 5/6/08
- Asheville, North Carolina – 5/7/08
- Wilmington, North Carolina – 5/9/08
- Winston Salem, North Carolina 5/9/08
- Morganton, North Carolina – 5/14/08

The meetings were advertised with letters sent to long-term-care services consumers, consumer advocates, Local Management Entities, County Department of Social Service Directors, and long-term-care services providers. The letters asked recipients to share the invitation with other stakeholders they knew. From these meetings, information was compiled and integrated into the Operational Protocol and will be considered as services are implemented.

Additionally, consumers, families of consumers, providers, and advocates were asked to participate in an application/nomination process for participation in ongoing Stakeholder Advisory Group meetings (see above). Members are defined as consumers and/or family members of consumers who receive publicly financed long-term-care services; agencies or providers; or representatives of people who are aging with care needs, have an intellectual or other developmental disability, have a physical disability, have a mental illness, or have a dual (or multiple) diagnosis.

Provider Involvement

Institutional providers, consumers, advocates, and State staff were invited to participate in provider issues workgroups. These providers will also be asked to participate in ongoing Stakeholder Advisory Group meetings.

Roles and Responsibilities

The stakeholders will be responsible for providing input to the six workgroup focus areas as well as to provider issues. An orientation to Money Follows the Person project components and deliverables was provided at the initial meeting of each workgroups and stakeholder group. At least one meeting was held for each workgroup focus area during development of the Money Follows the Person Operational Protocol; many groups met several times, and information was obtained through e-mails and telephone calls as well. During the implementation phase of the demonstration project, stakeholders at all levels will be responsible for providing input to the six workgroup focus areas and workgroups will meet on as needed. The six workgroup focus areas are

- Participant Recruitment/Enrollment/Informed Consent/Guardianship
- Housing

- Outreach, Marketing, and Education
- Provider Issues
- Benefits/Services/Consumer Supports/Self-Direction
- Quality Assurance/Continuity of Care

Operational Activities

Each year, the Division of Medical Assistance will coordinate four state forums to be held in conjunction with the Quarterly Stakeholder Advisory meetings. These meetings will rotate to locations around the state. These forums will be open to the pubic and efforts will be made to invite a wide range of potential participants; their families, friends, and guardians; providers; State staff; and other important community stakeholders.

Stakeholder involvement will continue to ensure successful implementation of Money Follows the Person demonstration. These meetings will be instrumental in moving forward with a long-term care system that provides an array of home and community-based services and supports designed to promote choice and independence. It is anticipated that these groups will continue to provide input into the implementation of the demonstration project through face-to-face meetings (four to six), emails, and conference calls.

Benefits and Services

Service Delivery Systems

In North Carolina, the Money Follows the Person Demonstration Grant project will be used to transition individuals into existing 1915(c) home and community based waiver programs. A separate demonstration 1915(c) waiver will not be created for the ongoing services provided through the Money Follows the Person Demonstration Grant project. Money Follows the Person participants will be enrolled in CAP waiver services or in the Program of All-Inclusive Care for the Elderly (PACE) the first day they transition into a community setting. These slots have been reserved in the waiver programs for Money Follows the Person demonstration participants. After 365 days of demonstration services, individuals will continue in the same 1915(c) waiver program or the Program of All-Inclusive Care for the Elderly (PACE) as long as they meet the eligibility requirements of the program.

North Carolina currently operates two 1915(c) waivers that target individuals who are aging and/or have disabilities as an alternative to residing in a nursing facility: CAP/DA and CAP/Choice. North Carolina also operates a 1915(c) waiver that targets individuals with intellectual or developmental disabilities as an alternative to residing in a private Intermediate Care Facility-Mental Retardation or a state-operated Intermediate Care Facility-Mental Retardation (developmental center): CAP/MR-DD.

Referrals to CAP/DA and CAP/Choice come from hospitals, Department of Social Services, provider agencies, advocacy groups, friends, family, nursing facilities, senior centers, Area Agency on Aging, and other sources. The majority of referrals come from Department of Social Services and hospitals. Upon referral, eligibility is determined and if eligible, a program assessment is performed and a plan of care/person-centered plan is developed. CareLine, Aging and Disability Resource Connections (where available) can link consumers to CAP/DA and CAP/Choice lead agencies.

The CAP/DA waiver is currently in the renewal phase. CAP/MR-DD Comprehensive waiver is being submitted as a new waiver July 2008 with anticipated implementation of November 2008. Services and benefits under the renewal waiver will be revised to include all demonstration services offered under the demonstration grant. Focus groups were held during the month of May 2008 as an effort to include needed comments regarding services and benefits from State staff, providers, consumers, and the community at large.

Division of Medical Assistance also has a 1915(bc) waiver, Innovations, known as the Piedmont Cardinal Health Plan. All Medicaid covered behavioral health and substance abuse services as, well as Innovations waiver services for the mentally retarded/developmentally delayed and operates in Cabarrus, Davidson, Rowan, Stanly, and Union counties. CAP/MR-DD does not operate in these counties. Persons transitioning from an intermediate care facility for the mentally retarded in one of these five Piedmont counties will not be able to participate in the Money Follows the Person demonstration project at the onset of the demonstration program. This is due to the fact that the Innovations waiver is authorized to serve 575 unduplicated participants during the current waiver year and is operating at full capacity. In addition, the Piedmont managed care waiver has generated savings and CMS has recently approved

reinvesting the savings into 1915(b)(3) services similar to Innovations services for the purpose of deinstitutionalization from Intermediate Care Facilities for the Mentally Retarded. However, the State will request an expansion in Innovations waiver capacity to allow these counties to participate in the grant if the 1915(b)(3) services are not adequate to fully fund Intermediate Care Facilities for the Mentally Retarded deinstitutionalization efforts. The State's goal is to amend the operational protocol requesting inclusion of the Piedmont counties, if appropriate, by 2010. CAP/DA services are included in these counties and individuals wishing to transition under this waiver will have the opportunity to do so.

The chart below describes the services currently covered under existing CAP waiver programs. The target population consists of North Carolina individuals who are currently residing in institutional care for a period of 6 months or more from one of the following categories: developmental disabilities, elderly and chronically ill, mental retardation, and physical disabilities.

Service Package

	Currently Covered Services		
	CAP/MR-DD	**CAP/DA**	**CAP/Choice**
Adult Day Health Care	YES	YES	YES
Augmentative Communications	YES $10,000/year limit	NO	NO
Case Management	State Plan Services	YES	NO
Consumer-directed Goods and Services (equipment and services not covered through State Plan that are needed to increase ability to complete activities of daily living and instrumental activities of daily living and to decrease dependence on aide services)	NO	NO	YES $600/year limit
Crisis Services	YES	NO	NO
Day Supports	YES	NO	NO
Employment Support	YES	NO	NO
Enhanced Respite Care	YES	NO	NO
Financial Management	NO	NO	YES
Home and Community Supports	YES	NO	NO
Home Modifications/Home Mobility Aids	YES $15,000 limit over waiver duration (3-year period)	YES $1500 year limit	YES $1500 year limit
Individual/Caregiver Orientation/Training/Education	YES	NO	NO
Institutional Respite Care	YES	YES	YES
Non-institutional Respite Care	YES	NO	NO
Personal Care Services/In-home Aide Services	YES (Personal Care Services & Enhanced Personal Care Services)	YES (In-home Aide Services)	YES
Personal Emergency Response Services/Telephone Alert	YES	YES (Telephone Alert)	YES
Preparation and delivery of meals (Meals on Wheels)	NO	YES	YES
Residential Supports (Group Homes)	YES	NO	NO

	Currently Covered Services		
	CAP/MR-DD	**CAP/DA**	**CAP/Choice**
Respite Care (In Home)	YES	YES	YES
Specialized Consultative Services (psych counseling, therapy counseling, nutrition counseling, etc.)	YES	NO	NO
Specialized Equipment	YES (Specialized Equipment) $1500/year limit	NO	NO
Transportation - Non-medical	YES ($1200/yr limit)	NO	NO
Vehicle modifications	YES $15,000 limit over waiver duration (3 year period)	NO	NO
Waiver Supplies	NO	YES	YES
Consumer-directed Care Advisor	NO	NO	YES

Program of All-Inclusive Care for the Elderly (PACE)

PACE is a managed care program that enables elderly individuals who are certified to need nursing facility care to live as independently as possible. The PACE provider receives monthly Medicare and/or Medicaid capitation payments for each eligible enrollee. The PACE provider assumes full financial risk for participants' care without limits on amount, duration, or scope of services.

Effective February 1, 2008, to enroll in this program, an individual must be Medicaid eligible and;

- Be 55 years of age or older
- Certified by the State to require nursing facility level of care
- Able to live safely in the community at the time of enrollment, and
- Reside in the service area of the PACE organization. Currently, PACE is only available in New Hanover and Brunswick counties through the Elderhaus, Inc. PACE (began operating February 1, 2008). Additionally, PACE sites are being developed in Fayetteville, North Carolina (projected start date of 2009) and Burlington, North Carolina (projected start of September 1, 2008).

Services provided by the Program of All-Inclusive Care for the Elderly (PACE) include, but are not limited to:

- All Medicaid-covered services, as specified in the State's approved Medicaid plan
- Multidisciplinary assessment and treatment planning
- Social work services
- Skilled nursing care
- Primary care physician services
- Medical specialty services
- Specialized therapies
- Recreational therapy
- Personal care services
- Nutrition counseling

- Meals
- Medical Supplies
- Home Mobility Aides
- Transportation
- Prescriptions
- Laboratory tests, X-rays, and other diagnostic procedures
- Prosthetics, orthotics, durable medical equipment and corrective vision devices

State Plan Services
In addition to the waiver program services, all Money Follows the Person participants will be eligible for Medicaid State Plan Services.

Home and Community Based Demonstration Services
Under the demonstration grant, demonstration services will be provided and reimbursed with demonstration funds when not covered under current CAP waiver services and benefits. In North Carolina, these services are essential for successful transition to the community and propose through CAP waiver renewals to continue the services after the Money Follows the Person demonstration period for waiver participants ends. It will not be necessary to set units and rates as these are cost reimbursement services. The chart below shows the demonstration services.

Demonstration Services	Add to Waivers
Assistive Technology	CAP/Choice CAP/DA
Transition Services	CAP/DA CAP/Choice CAP/MR-DD
Family Support (Training/Education)	CAP/DA CAP/Choice
Transition Coordination Services (while transitioning an individual from an institution)	31-60 days for CAP/DA, CAP/Choice

Home and Community Based Supplemental Services
At this point, North Carolina does not intend to offer supplemental services. However, consideration is being given to amending waivers in future years to include transition coordination up to 61-180 days prior to transitioning into the community. North Carolina will take the next twelve months to strategize for a systems change in this area. Once this is accomplished, an amended Money Follows the Person Operational Protocol will be submitted to CMS.

Service Definitions

Assistive technology provides assistive devices, items and/or technology that aid persons with activities of daily living so they can be more independent. The State will incorporate assistive technology devices not currently covered such as:

- security devices (example: remote keyless entry systems);
- reminder systems/devices (example: systems connected to the internet to announce reminders over an intercom system), and
- medication dispensing devices

Transition services are one-time set-up expenses for individuals who are transitioning from a nursing facility, a state-operated developmental center or private Intermediate Care Facility-Mental Retardation group home to a community setting or another living arrangement where the person is directly responsible for his/her own living expenses and include the following:

- Security Deposits
  - Security (apartment/home)
  - Utility
    - Land Line phone
    - Water
    - Electricity/Gas
- Appliances
  - Washing machine
  - Dryer
  - Refrigerator
  - Microwave
  - Food preparation items
- Essential furnishings
  - Table
  - Chairs
  - Sofa/ Couch
  - Dresser
  - Bed
  - Window coverings
- One-time cleaning prior to occupancy
- Health and Safety Assurances
  - Pest eradication
  - Allergen control

Transition services are furnished only to the extent that the person is unable to meet such expense or when the support cannot be obtained from other sources. Transition services do not include monthly rental or mortgage expenses; regular utility charges; and/or household appliance or diversion/recreational items such as televisions, VCRs, and DVDs.

The monetary limit for transition services limit is $3,000.00. Transition services will be provided only once and may not be accessed for any subsequent moves within or into the community. Transition services are only available once in the lifetime of waiver enrollment and must be accessed within 90 days of the first day of transition. Funds should be used to meet

needs that are barriers to transition. Sound judgment should be used when approving services to ensure purchase are modest and reasonable. Funds cannot be used to pay existing bills, past due balances, rent or groceries.

Family support services provide services and funds to assist the family in support activities. The service may involve support activities such as assisting the family in developing skills to effectively interact and manage the individual; understand the causes and treatment of health issues; understand and utilize the system; and plan long term for the individual and the family.

Transition Coordination/Transition Case Management assists individuals in gaining access to needed medical, social, education, and other services for persons moving from a Medicaid-funded institution to a qualified community residence. For Money Follows the Person, a qualified residence is:

- A home owned or leased by the individual or the individual's family member; or
- An apartment with an individual lease, with lockable access and egress, and that includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control, or
- An apartment with an individual lease, with lockable access and egress, and that includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; or
- A residence in a community-based setting in which no more than four unrelated individuals reside

Currently, transition coordination services are offered for up to sixty days prior to transitioning into the community under CAP/MR-DD Comprehensive and thirty days prior to transitioning into the community under CAP/DA and CAP/Choice services. State staff will design a transition coordination service category which will incorporate transition coordination to appropriately meet the needs of the populations being transitioned and resubmit an amended Operational Protocol once approved under amended waivers.

Waiver amendments

North Carolina will submit to CMS on August 1, 2008 two new CAP-MR/DD waivers. These waivers will include a Supports waiver and a Comprehensive waiver, both to be implemented November 1, 2008 (per CMS approval) when the current Comprehensive waiver expires. The CAP/DA renewal will be submitted to CMS for approval by September 30, 2008.

Wait List

Individuals will transition into a CAP waiver or PACE on the first day in the community. Slots have been reserved in each waiver program (CAP/DA, CAP/MR-DD, and CAP/Choice) and PACE for Money Follows the Person participants. Currently, North Carolina gives priority to individuals transitioning out of nursing facilities and intermediate care facilities for the mentally retarded (state and private). Therefore, there will be no wait list for those wishing to transition to the community.

Dis-enrollment/Re-enrollment

A Money Follows the Person participant who is re-institutionalized for a period *greater than 30 days* will be categorized as **disenrolled** from the program. However, a disenrolled individual may re-enroll in the program without re-establishing the six-month institutional residency requirements. As long as a former participant meets Medicaid waiver eligibility criteria, the participant will still be eligible for Money Follows the Person services at the enhanced Federal Medicaid Assistance Percentage match. However, if the former participant remains in the qualified institution beyond six months, the participant will be defined as a "new" Money Follows the Person participant in terms of the Money Follows the Person services and the Federal Medicaid Assistance Percentage.

A former participant may re-enroll in the program after being re-evaluated and after having an updated plan of care/person-centered plan. Once the individual is assessed to be appropriate for home and community based services, a referral will be made to the case manager for development of the individualized plan of care/person-centered plan that addresses any change(s) in the status of the Money Follows the Person participant and/or any lack of necessary supports in the community. After three incidences of re-institutionalization of 30 consecutive days or longer, the re-institutionalized Money Follows the Person participant will not be considered for reentry into the Money Follows the Person project.

Transition at termination

The 1915(c) waivers and the Medicaid State Plan Services will continue to provide services at the termination of the Money Follows the Person project. Program participants will also be assisted to access other community-based services for which they may qualify. At the end of demonstration services, CAP waiver services and benefits for which an individual qualifies will support continued community and home based living. This will result in no loss of services and supports to individuals who transitioned under demonstration services.

Consumer Supports

Educational Materials
Division of Medical Assistance will develop informational brochures that outline the services provided through Money Follows the Person. Current consumer information will be updated to include information about the Money Follows the Person Demonstration Grant project. The systems listed in this section are various ways for Money Follows the Person participants to access consumer supports when needed (such as in a non-911 emergency). Specifically, each participant's plan of care/person-centered plan will have concise methods to address the individual's needs in regards to supports, services and back up plans. For specifics on risk management, critical incident, and 24-hour back up, refer to the Quality section.

Back-up Systems
CARE-LINE. The North Carolina Department of Health and Human Services toll-free information and referral telephone service, CARE-LINE [1-800-662-7030; local calls: 855-4400 or 919-733-4851 (TTY)], is available to provide information and referrals regarding human services in government and non-profit agencies. A database of over 10,000 agencies across North Carolina is available to staff who are assisting callers. The CARE-LINE is available 24 hours, 7 days a week. Consumers, their families/guardians, and other customers have a service to call which provides information and referrals on a wide array of human services any time of the day or night.

NCcareLINK. North Carolina maintains a comprehensive health and human services web site called NCcareLINK (http://www.nccarelink.org). It is a collaborative effort of the North Carolina Department of Health and Human Services and many other government and non-profit information and referral stakeholders across North Carolina. This web site provides up-to-date information about programs and services across North Carolina for families/guardians, seniors, youths and everyone in-between (see Attachment F).

NCcareLINK system:
- Provides current consumers with local resources
- Introduces potential consumers to local resources
- Outlines services for persons moving to North Carolina
- Provides a marketing opportunity for local providers
- Helps Local Management Entity staff make appropriate referrals to provider agencies.

NCcareLINK has been designed with the end-user in mind. Partnering agencies—through a Memorandum of Understanding with the Office of Citizen Services—provide six month updates to the system on all of the Providers in their region. Partnering agencies are:
- non-profit entities that offer health and human service programs
- Government agencies (local/state/deferral)
- Self-help/support groups
- Faith-based organizations that offer specific health and human services program(s) to the community
- Civic/social groups that offer specific health and human services programs(s) to the community

- For-profit agencies that offer a sliding scale payment plan or accept governmental funds or offer unique services that meet health and human services needs at the community level
- An organization must be in business providing specific service(s) for a minimum of six consecutive months, have an established physical address and contact telephone number, and have a license to provide services.

Individuals may also access 911, the statewide suicide hotline at 1-800-273-8255, and/or visit the emergency room at a local hospital.

Personal Emergency Response System (PERS). Personal Emergency Response System is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals from the company ADT Security Services. Personal Emergency Response System services are limited to those individuals who live alone, or who are alone for significant parts of the day, who are alone for any period of time and have a written plan for increasing the duration of time spent alone as a means of gaining a greater level of independence, or who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

The Personal Emergency Response System may be helpful in the following situations:

- A fall has occurred and the individual cannot get up on their own. The attendant on the other end of the response system would obtain the information regarding the emergency and respond according to the nature of the emergency.
- A personal care attendant does not show up. The individual would make a call using the Personal Emergency Response System and appropriate action would be taken.

24 Hour Back up

PACE

In each participant's service plan a back up plan for needed care coverage that includes formal and informal supports is included. However, there are times when the most comprehensive plans can be insufficient. For this reason, each PACE center is required to have a 24/7 on-call staff person who is able to assist any PACE participant who is in a crisis or emergency who needs to obtain access to critical medical supports. The PACE participant, their legal guardian (as applicable) and family members are informed of how to access the 24/7 on-call system during the intake and assessment process, and in their service plan. This information is reviewed on an annual basis and as needed with each participant. The on-call person is either a physician or registered nurse. PACE on-call staff documents all calls taken during the center's non-operational hours and the action taken to address the participant's issue or problem. The call and resulting action is also documented in the participant's record. It is the responsibility of the *PACE* Program Manager to monitor the *PACE* Center to ensure the 24/7 system is working and that 24/7 coverage needs are identified and addressed adequately and in a timely manner. The Division of Medical Assistance PACE Program Manager reviews monthly reports of calls to the center's 24/7 system and provides feedback as necessary related to any improvements in the handling of calls to this system.

CAP/DA and CAP/Choice

In each participant's service plan a back up plan for needed care coverage that includes formal and informal supports is included. However, there are times when the most comprehensive plans can be insufficient.** For participants with diagnoses that require rapid access to Emergency Medical Services CAP/DA provides for the use of telephone response systems. The CAP/DA case manager checks this system on a monthly basis to ensure it works properly and reviews any reports from the Emergency Response System Provider. This case management activity is documented in the client's case notes.

For other non-emergency but critical support needs, the CAP/DA Case Manager is available to assist the participant during the agency's normal business hours. Information regarding these interactions is available to Division of Medical Assistance staff during participant record reviews during lead agency site audits. In addition, the case manager is required to perform a monthly review of the provision of services with both the client and the agency providing the services. Any deviation in waiver service provision is to be documented in case manager's notes and a detailed description of how the client's needs were met are included. Division of Medical Assistance staff provides feedback regarding any deficiencies noted during the review including inadequate actions and issues not handled in a timely manner.

After hours, North Carolina's **CareLine**, a toll-free hotline designed to assist North Carolina citizens in need of supports and services, has live operators 24 hours a day, seven days a week. The **CareLine** operator is able to assess a participant who is in a crisis or emergency and can coordinate access to critical medical supports. **CareLine** staff logs and tracks each call and compiles reports and recommendations for each encounter. The Division of Medical Assistance recognizes the importance of evaluating this data and will work collaboratively with the **CareLine** program to develop regular reporting and a method for evaluating and using this information to improve the quality of CAP/DA. The volume and types/categories of calls (e.g. – absence of personal care attendant, failure of durable medical equipment, etc.) and whether the responses were adequate and timely will be evaluated and addressed as a part of this process. MFP clients will be flagged in the system and a report will be generated specifically on these clients.

The CAP/DA participant, their legal guardian (as applicable) and family members are informed of how to access all aspects of 24 hour back up by the case manager during the intake and assessment process, and in their service plan. This information is reviewed monthly by the case manager as a part of their monthly monitoring requirements, assessed on an annual basis during the continued need review and as needed with each participant.

* CAP/CHOICE is administered by the CAP/DA Lead Agencies; therefore, when CAP/DA is referenced in this document it is understood that CAP/Choice applies as well.
** 24 Hour Care Coverage Plans are completed for only those participants identified as needing around the clock care supports critical for his/her health and welfare. For the purposes of the Money Follows the Person Project all participants designated for MFP are required to have a 24 hour coverage plan, regardless of the need for 24 hour care coverage.

CAP/MR-DD

The CAP/MR-DD waiver guidelines require all providers to have a process for ensuring 24 hour back-up (24/7/365) availability, so that a live person is accessible when needed. All participants of CAP/MR-DD waiver services are informed of and provided with information related to back-up staff at the time of identification of provider and during the person centered plan/plan of care planning process.

Providers of 24 hour services and Targeted Case Management services act as the First Responders if and when the participant or a member of their support system initiates contact for assistance in the case of an emergency. The provider is required to notify the participant and his or her support system of the process for accessing emergency services 24 hours a day, 7 days a week, 365 days a year, both orally and in writing at the initial contact. The notification includes contact information for an alternate source of assistance in the eventuality that the provider is not available.

The person centered plan/plan of care is expected to address how the provider will ensure back-up staff is available, if the staff regularly assigned to provide services are unavailable. The back-up staff must be trained to meet the specific needs of the participant, as detailed in the person centered plan/plan of care, including health, mobility, communication, risks behavioral issues, and skill training.

Each provider will be required to document and track receipt of calls and requests for back-up staff and staff unavailability. This report will be submitted to the Local Management Entity on a monthly basis for tracking and analysis.

Critical Incident Management

PACE

The state, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation. All incident reports are provided to the PACE Program Manager for review, including critical incident reporting. Reports are reviewed to ensure that appropriate action was taken at the time of the incident, whether further investigation is needed, or if further action or training may be required to ameliorate and/or prevent any recurrence of the incident. Each PACE Center is required by CMS to report all critical incidents to CMS. All information provided to CMS is also submitted to the North Carolina *PACE* Program Manager for review.

CAP/DA and CAP/Choice

The State, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation. Case managers will be required to report monthly on substantiations of abuse and neglect for Money Follows the Person participants.

Additional critical incidents for the aged and disabled population include falls, unplanned weight loss and unplanned hospitalizations. These are reported during the initial assessment, at annual continued need review and as needed in change of status assessment. Data is collected and accessed through Automated Quality and Utilization Improvement Program. Reports are run quarterly are reviewed to ensure that appropriate action was taken at the time of the incident. Reports are provided to the lead agencies and Division of Medical Assistance staff.

CAP/MR-DD Comprehensive

North Carolina Administrative Code 10A NCAC 12G.0603 requires all Local Management Entities and agencies providing mental health, developmental disabilities or substance abuse services to any person receiving public funds to participate in the Division of Mental Health/Developmental Disabilities/Substance Abuse Services-coordinated system for responding to and reporting critical incidents and other life endangering situations. This will include the Money Follows the Person participants. Critical Incidents are defined as any happening which is not consistent with routine operation of a facility or service in the routine care of participant and that is likely to lead to adverse effects upon the consumer. This system addresses deaths, injuries, behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and participant behavior issues.

Providers are responsible for responding to all incidents and submitting to the Local Management Entities reports on all Level II incidents (e.g., incidents where police are involved, injuries requiring medical treatment). Providers submit to both the LME and to Division of Mental Health/Developmental Disabilities/Substance Abuse Services reports on all Level III incidents (e.g., incidents that cause permanent injury or death). Providers also report quarterly aggregate information to the Local Management Entities on a Level I incidents (e.g., injuries that do not require hospitalization or medical treatment other than first aid).
Local Management Entities are responsible for ensuring that providers submit incident reports as required and respond appropriately to minimize harm from the incident and the likelihood of future incidents.

Local Management Entities must report to Division of Mental Health/Developmental Disabilities/Substance Abuse Services quarterly on their analysis and response to trends on all incidents and deaths as part of the Performance Contract with the Department of Health and Human Services. The Division of Mental Health/Developmental Disabilities/Substance Abuse Services Quality Management and Customer Services Community Rights Teams provide oversight and technical assistance to the Local Management Entities to ensure that Level III incidents are fully addressed by providers.

The Division of Mental Health/Developmental Disabilities/Substance Abuse Services Quality Management (QM) Team maintains an internal database on reported Level III incidents. From this data and the Quarterly Incident Reports submitted by the Local Management Entities, quarterly and annual trend analysis reports are created and reviewed by the team for comparison on a Local Management Entities level. The Quality Management Team reviews the reports to identify trends that may need to be responded to by remediation and improvement activities to assure that the underlying philosophy and assurances of the CAP-MR/DD waiver are maintained. The Internal Quality Management Review Committee (See Section IV of Quality Management Plan) will also review these reports to identify trends and issues that may need remediation and improvement activities

Risk Management

PACE

Diagnoses and symptoms that pose a significant risk to health, safety, and well-being of each PACE participant are identified during an on-going interdisciplinary assessment process that is very thorough and comprehensive. Each risk identified by the assessment process must be addressed in the individual's service plan. For example, an individual identified with a fall risk may need to have assistance while ambulating through the use of gait belt, or, an individual with a history of bowel obstructions may require a more thorough monitoring of bowel movements and/or a specialized diet to help prevent hospitalizations. Since PACE Centers serve a significant number of individuals with cognitive impairments and/or dementia, wandering and elopement is often an issue. Any individual identified with a dementia-like diagnosis is monitored using a Wander-guard system. The North Carolina PACE Program Manager will monitor Service Plans with special consideration given to diagnoses and symptoms where risk is more inherent and evaluate if these risks are addressed adequately. Any service plan that is deficient in this regard must be amended before approval. Additionally, any interventions designed to minimize risk will be assessed during site reviews to assure they are functioning and are being implemented as designed and intended.

CAP/DA and CAP/Choice

Diagnoses and symptoms that pose a significant risk to health, safety, and well-being of each CAP/DA and CAP/CHOICE participant is identified as part of the intake and assessment process. These items are entered into the Automated Quality and Utilization Improvement Program assessment tool along with the Service Plan which is completed using the Automated Quality and Utilization Improvement Program Plan of Care Tool. The Automated Quality and Utilization Improvement Program system has the capacity to compare identified risk factors with elements of the plan to ensure these risks are adequately addressed for all CAP/DA and CAP/CHOICE participants. Each risk identified by the assessment process must be addressed in the individual's service plan.

Some example scenarios where service plans should address risk factors identified in the assessment process include:

a) An individual identified with a fall risk may need to have assistance while ambulating through the use of gait belt

b) An individual with diabetes requires continuous monitoring of blood glucose levels (AC1s), specialized diet and physical activity.

c) An individual with a history of decubitus ulcers requires regular and continuing monitoring of skin to detect and prevent skin breakdowns

d) An individual with hypertension will require regular and continuing monitors of blood pressure

Additionally, case managers monitor service plans with special consideration given to diagnoses and symptoms where risk is more inherent and evaluate if these risks are addressed adequately on at least a monthly basis. Assessments are completed at intake, during continued need reviews, or as needed, when the health of the participant changes. Every time the assessment (initial,

CNR, or a change in status) is completed, a plan of care is completed or amended based upon the most current assessment.

Automated Quality and Utilization Improvement Program generates reports of service plans that do not address risk factors identified in the assessment. These reports are reviewed by CAP/DA staff and feedback is provided to the specific CAP/DA lead agency where the assessment and service plan were completed. The interventions, as set forth in the individual's service plan, designed to minimize risk will be assessed during site reviews to assure they are functioning and are being implemented as designed and intended.

CAP/MR-DD Comprehensive

As a preliminary step, the MR2 assessment form which documents Intermediate Care Facility for the Mentally Retarded level of care, along with the North Carolina-Service Needs Assessment Profile (NC-SNAP), will be used to identify potential risks to the participant. A Crisis Prevention Plan is incorporated within the person centered plan/plan of care. The Crisis Prevention Plan includes supports/interventions aimed at preventing a crisis (proactive) and supports and interventions to employ if there is a crisis (reactive). The proactive plan aims to prevent crises from occurring by identifying health and safety risks and strategies to address them. The reactive plan aims to avoid diminished quality of life when crises occur by having a plan in place to respond. The planning team are to consider what the crisis may look like should it occur, to whom it will be considered a "crisis", and how to stay calm and to lend that strength to others in handling the situation capably.

Other assessment tools will be utilized to identify potential risks for all Money Follows the Person participants. The Risk Assessment tool identifies potential risk, such as but not limited to, situational, environmental, behavioral, medical, and financial risks. If a risk is identified and the planning team concurs, the risk identified will be documented within the Crisis Prevention Plan of the Person Centered Plan. The Supports Intensity Scale (SIS) is an assessment tool that measures practical support requirements of a person with an intellectual disability. Unlike traditional assessments, the SIS focuses on what daily supports a participant needs to live as independently as possible within their community. A major strength of the Supports Intensity Scale is that it identifies supports that are needed to help a participant be successful in a variety of life domains. As such, during the person centered plan/plan of care planning meeting, as needs are identified, corresponding supports should also be identified to assist the consumer in meeting those needs. The person centered plan/plan of care will identify and document strategies to address risks identified in the Risk Assessment Tool and the Supports Intensity Scale. The Risk Assessment Tool and the Supports Intensity Scale can be used independently or in collaboration to identify potential risk to the participant.

Consumer Complaints

The Department of Health and Human Services Ombudsman Program was created to address inquiries and complaints that consumers and their legal/guardians have regarding services that Department of Health and Human Services oversees or administers. Through this service, Office of Citizen Services staff serves as the central point of contact for the Department of Health and Human Services Secretary's Office, Governor's Office, other elected and appointed officials, department personnel, all government agencies, non-profit and private agencies, advocates and residents of the state.

Constituents who contact their governmental representatives or any human service professional with complaints concerning Department of Health and Human Services or who are in need of human service programs are referred to the Department of Health and Human Services Ombudsman Program. When a complaint is received, Office of Citizen Services staff serves as a liaison between the resident and the Department of Health and Human Services program specialist. Office of Citizen Services' staff ensures that complaints are thoroughly examined and investigated. Staff determines the most appropriate parties to contact and work with to resolve the situation. Feedback is provided to elected officials regarding their constituents' concerns. Ensuring that consumers have the proper channel for addressing their concerns is the key to this program. If a person's complaint is valid, steps are taken to rectify the situation. If the complaint is not valid, time is spent with the resident to educate him/her on the process and help the person understand why the situation was handled in a certain manner. In addition, staff relies on an extensive statewide database to give additional referrals that may be of assistance.

The Regional Long Term Care Ombudsmen program can also be accessed through the CARE-LINE and is available 24 hours a day/7 days a week, by calling 1-800-662-7030 (English/Spanish) or 1-877-452-2514 (TTY).

Self-Direction

Self direction is an *option* currently afforded to individuals under CAP/Choice waiver program CAP/Choice is a program of participant-directed care those who are elderly and/or have a disability, and/or their family/guardian, who wish to remain at home and have increased control over their services and supports. CAP/Choice reflects North Carolina's health reform policy objectives of promoting consumer choice and decision-making, reducing health-care costs, and identifying key stakeholders, especially consumers in its approach to reform the delivery of services. North Carolina's Division of Medical Assistance is committed to expanding the CAP/Choice program statewide. The services under CAP/Choice are currently offered in four North Carolina counties: Cabarrus, Duplin, Forsyth, and Surry. The waiver was approved March 31, 2008 with a retroactive date for services of January 1, 2008. A systematic roll-out to all of North Carolina's remaining counties will begin January 1, 2009. CAP/Choice services will become an option under the traditional CAP/DA waiver program, which is already implemented statewide. Training specific to CAP/Choice will be provided to the CAP/DA lead agencies not already providing CAP/Choice services.

North Carolina's Money Follows the Person Demonstration Grant project includes the same services as the CAP/Choice waiver with regard to compliance with the Freedom of Choice requirement. Participants and/or their family/guardian may choose any willing and qualified provider; receive information about providers; select whom to interview; and meet, interview and select the provider of their choice. CAP/ Choice participants have the opportunity to hire a personal assistant who is a family member, friend, or neighbor. Any individual hired by the CAP/Choice participant is not required to be an employee of a provider agency.

Under CAP/Choice, participants will be able to:
- Choose (hire) the Personal Assistant who will provide their care support
- Train, supervise and evaluate the worker
- Negotiate the rate of pay and other benefits
- Terminate the worker should this become necessary
- Select individual providers and direct reimbursement for specified waiver services
- Engage in a cooperative working arrangement with a financial manager (FM) who will pay the participant's worker, handle federal/state taxes and other payroll/benefit functions related to the employment of the worker, and reimburse service providers under the direction of the participant.

Self-Direction Support Provisions: Self-Directed Services is an option afforded the individual (or in the case of children, their parents or other legally responsible relatives) and others that the individual asks to assist him/her to direct some or all of the services and supports in their person-centered plan Self-directed means that the individual or the family (in the case of minors) hires and directs the provider of services and directly authorizes the financial management services provider to make payment on the participant's behalf for a goods or service included in the person-centered plan.

Care advisors will inform individuals and/or families/guardians of the option to direct services and supports during the assessment and person-centered planning process. Each plan of care will

include a risk assessment and identify appropriate risk management strategies. The individual who desires to direct his/her services will be assessed to determine if the individual is able to independently direct services. If the individual has a court appointed guardian, is a minor, or is assessed as needing assistance to direct services, a representative will be required for the individual to participate in Self-Directed Supports Option. The representative may be a family member, friend, legal guardian, other legally appointed representative, or income payee. A person who provides services to the individual may not be the representative. This includes any employee of a licensed facility where the individual lives or any member of an Alternative Family Living or foster home where the individual resides. The representative must:

- Demonstrate knowledge and understanding of the individual's needs and preferences
- Agree to a predetermined level of contact with the individual
- Be willing and able to comply with program requirements
- Be at least 18 years of age
- Be approved by the individual and/or his/her legal representative to act in this capacity.

Care advisors will be responsible for identifying the need for a representative for the individual and assuring that the representative meets established criteria.
Individuals who are considering the Self-Directed Supports Option will be provided educational opportunities and materials. They will have further educational opportunities through individual training and education services. The individual and/or their guardian, in conjunction with the planning team, will assess the need for Supports Brokerage and the specific activities to be performed for CAP/Choice participants. Care advisors will also be responsible for ensuring that the person-centered plan identifies how emergency back-up services will be furnished for workers employed by the individual and/or their guardian. As an added safeguard, provision may be made via on-call service agreements with licensed home health agencies to provide staff in the event that emergency back-up strategies, identified in the person-centered plan, cannot be implemented and there is the potential that the person's health and welfare would be jeopardized. The individual's care advisor will authorize the provision of these on-call emergency back-up services.

Refer to Attachment G for further details regarding self-direction as an option for individuals under CAP/Choice services. Note: Section III.n. (which indicates # of participants) is only a **goal** (a CMS required component of the waiver development) for North Carolina and is not an indication of the exact number of projected participants. Everyone enrolled in CAP/Choice will be afforded this option.

Self Direction is not available for individuals enrolling in CAP/MR-DD waiver program. North Carolina will submit to CMS on August 1, 2008 two new CAP-MR/DD waivers. These waivers will include a Supports waiver and a Comprehensive waiver, both to be implemented November 1, 2008 (per CMS approval) when the current Comprehensive waiver expires. The Supports Waiver will have the option to self-direct services including budget authority as well as employer authority. It should be noted that individuals served under the Supports waiver are individuals with more limited intensity of support needs who are currently reside in the state developmental centers. These individuals will have self-direction available to them. Individuals participating in Money Follows the Person would need more intensive services than the Supports waiver will

provide and will therefore be enrolled in the Comprehensive waiver. These individuals will not have self-direction available to them.

Quality

The purpose of the Quality Management Strategy is to ensure that discovery processes and systems for remediation and quality improvement take into consideration the specific and unique needs of individuals with developmental disabilities, mental retardation, physical disabilities and the elderly when they leaving public institutions and Private Intermediate Care Facilities-mental retardation. The quality management plan includes oversight of the success of the transition process, successes and barriers experiences in community living, effectiveness of back-up systems, and risks that might lead to re-institutionalization.

North Carolina is aware that the Money Follows the Person demonstration grant occurs within the State's overarching Quality Management Strategy for home and community based waiver services. To the degree possible it will enable the State to collect data across all waivers and all waiver participants and compare data between Money Follows the Person and non- Money Follows the Person waiver participants.

The North Carolina Quality Management Strategy is designed to capture data and address issues at every level – individual, provider, local management entity and lead agencies, and state. The assurances (level of care, service plan, qualified providers, health and welfare, and administrative authority) are addressed. Additionally, each waiver will address risk management, 24-hour back up, and critical incidents are required for Money Follows the Person participants.

CAP/DA and CAP/Choice waivers are currently in renewal and/or new submission status. It is anticipated that CAP/DA will be approved by CMS September 2008 and CAP/MR-DD November 2008. Each waiver will incorporate the required 3.5 version and will include all assurances, risk management, 24-hour back up, and critical incident as required for Money Follows the Person participants. Attachments H, H1 and I describe each waiver's Quality Management Strategy:

- Attachments H: CAP/DA and CAP/Choice.
- Attachments H1: CAP/MR-DD.
- Attachment I: PACE. PACE is a three-way agreement between the program, the State, and CMS and is an approved waiver using the 3.4 version.

Housing

The lack of affordable and accessible housing in North Carolina remains a significant barrier to meeting the needs of extremely low income households, the elderly, and persons with disabilities, in their communities. However, North Carolina has made significant, if limited, progress in this area over the past five years. In May of 2002, the Secretary of the Department of Health and Human Services established the position of Housing Coordinator within this office. The Department of Health and Human Services Housing Work Group (HWG), with representatives of all Department of Health and Human Services service divisions, was formed to implement the broad agenda for this new initiative: reducing fragmentation of housing efforts within the Department; increasing the housing capacity of the State and local agencies to maximize existing housing resources; and more effectively engaging the affordable housing industry to expand supportive housing opportunities for Department of Health and Human Services constituents.

Ensuring Sufficient Qualified Residences

As a result of this department-level commitment, the North Carolina Housing Finance Agency has partnered with the Department of Health and Human Services since 2002 to facilitate the inclusion of persons with disabilities within Low Income Housing Tax Credit (Housing Credit) properties. All Housing Credit properties funded in North Carolina since 2004 must develop a Targeting Plan that makes 10% of the units available to extremely low income persons with disabilities, including those who are homeless. To date, over 1,175 units of quality, affordable rental housing have been funded. The Key Program, an operating assistance program created by the North Carolina Housing Finance Agency and the Department of Health and Human Services, is also available to Housing Credit properties funded since 2004 to ensure that targeted units are affordable to persons with incomes as low as Supplemental Security Income (SSI). Since 2006, 5% of units in all new Housing Credit properties must meet a higher than legally mandated level of accessibility, including curbless showers and full-turn-around bathrooms.

In 2004, the Department's Housing Work Group prepared a successful grant application to CMS for a Real Choice Systems Change Grant: Integrating Long-Term Supports with Affordable Housing. The grant, a partnership between the Department of Health and Human Services and the North Carolina Housing Finance Agency, was designed to bring technical assistance to local communities to expand the collective capacity of the human service system to implement the Housing Credit targeting partnership and promote the expansion of affordable community housing opportunities integrated with long-term supports.

The Department of Health and Human Services is seeing additional tangible results from collective, cross-disability housing advocacy. The 2006 and 2007 legislative budgets included substantial increases in funding to expand the Housing 400 Initiative, the Department of Health and Human Services–Housing Finance Agency partnership in addressing the housing needs of extremely low income persons with disabilities. In total, $18.4 million of capital funding to the North Carolina Housing Trust Fund and $5.2 million of recurring funds for the Key Program have been appropriated to expand production of a range of independent and supportive housing units targeted to persons with disabilities and incomes as low as SSI.

While these are housing resources that were not available five years ago, the continually shrinking supply of federally subsidized housing resources means that Money Follows the Person participants will be challenged to locate safe, decent, accessible, and affordable housing in communities of their choice. Participants will, however, be able to avail themselves of significant improvements developed as part of the Real Choice Grant in the available tools and capacity of supportive service providers to assist them in finding and accessing housing resources.

These tools include county-specific listings of affordable housing resources for each of North Carolina's 100 counties and an Affordable Housing Primer that gives basic information about navigating the affordable housing system, including North Carolina–specific contact information for housing programs across the state. These tools are now posted and updated on the website of the North Carolina Housing Coalition. North Carolina has also implemented an online housing search tool, www.NCHousingSearch.org, which is currently operational and marketing to landlords. Searchable by a number of criteria (location, proximity of transportation, accessibility, etc.), this service is designed to provide real-time information, posted by participating landlords, of units available for rent across the state. A statewide inventory of affordable housing resources is in the development stage.

Service providers working with Money Follows the Person participants will be invited to join one of 30 Housing Support Committees organized across the state. Access to the Housing Credit and Housing 400 Initiative units is managed at the local level by the Housing Support Committee, a collaborative of human service providers who have come together to make referrals to these new housing opportunities and ensure that tenants have access to the ongoing supportive services they may need to live successfully in the community. As each new property is funded, a Local Lead Agency (LLA) is identified who will represent the local Housing Support Committee in dealing with property management. Members of the Housing Support Committee make referrals to the property owner and the Local Lead Agency maintains a waiting list, in the event of turnover, once the specified number of targeted units is occupied. The Housing Support Committee members are also knowledgeable about other affordable resources, as well as the range of community services and providers available in their community.

North Carolina has 131 public housing agencies (PHAs) or Housing Choice Voucher administering agents. The availability and quality of public housing units varies across locations. The availability of Housing Choice Vouchers is more limited, with many locations having closed waiting lists or waits up to two and three years. Over the past few years, most, if not all, public housing agencies have been approached by the disability community, through the Housing Support Committee or other efforts, about re-establishing a preference for persons with disabilities. While this has been successful in some areas, in others it has not, where public housing agencies are responding to pressure on their budgets to direct assistance to higher income levels. Efforts to engage public housing agencies for the benefit of the Money Follows the Person target populations will continue.

Although sometimes a challenge, individuals with developmental disabilities have a variety of options available for housing in the community. Supported living arrangements are available also using state funds in conjunction with waiver funding. These settings support individuals to

live in their own apartment or in settings of one to three. Many individuals served through the CAP-MR/DD waiver are housed in alternative family living arrangements with families using waiver funding. In addition, the NC legislature has proposed in their fiscal year 2009 budget the allocation of additional funding to the Area Resource Center of North Carolina to provide housing to individuals with developmental disabilities.

Access to other qualified residences—community-based settings housing no more than four individuals—will likely require providers who are willing to re-tool existing residential settings licensed under North Carolina facility rules. Supervised Living settings are licensed under Mental Health, Developmental Disabilities and Substance Abuse rules; Family Care Homes are smaller board-and-care facilities. Both may serve as few as two individuals, but the majority of these settings are currently serving the maximum number allowed by the rules (six persons in Supervised Living and seven in Family Care).

With additional targeted rental units, within both Housing Credit properties and smaller scale supportive housing developments, now continuously coming on line, Money Follows the Person participants who can live independently, and/or with in home assistance, will transition to independent rental housing. Many of these apartments are being constructed to provide a high degree of accessibility, bathrooms designed to allow full toilet transfers and curbless showers, features that will support a high degree of independence for persons with mobility impairments. For persons being transitioned who need a higher level of care or supervision, North Carolina anticipates their transition to small, 4 or less person, licensed shared living arrangements.

Qualified Residences

Refer to **Attachment K** for a list of defined qualified residences.

Continuity of Care Post Demonstration

The State's efforts to rebalance long-term care support programs and meet demonstration objectives include continuity of care post demonstration. Money Follows the Person participants will be accessing existing 1915(c) waivers (CAP/DA, CAP/MR-DD Comprehensive, CAP/Choice) and Program of All-Inclusive Care for the Elderly (PACE). Participants will continue to be served through these waivers in the post-demonstration period as long as they continue to meet the eligibility criteria. Therefore, there will not be a lapse in services for Money Follows the Person demonstration participants and a transition plan is not required.

For those participants who do not meet waiver qualifications after 365 days of demonstration services, a transition service plan will be developed and assistance with referrals to supportive programs will be provided. Referrals may include connecting participants to local Councils on Aging and/or Departments on Aging, which coordinates aging services that provide transportation, personal care, chore services, adult day care, information and referral, outreach, and case management. For people with physical disabilities, a referral to the regional Center for Independent Living for assistance with services as well as a referral to the Department of Social Services for assessment of appropriate services will be made. For individuals needing personal care assistance, the State Medicaid Plan can be accessed.

Referrals will also be made to regional Aging and Disability Resource Connections. The Aging and Disability Resource Connections are an important community resource that can provide support to Money Follows the Person participants who are elderly and/or with disabilities regarding such services as insurance counseling, information referral and assistance, emergency rent assistance, and caregiver support. Aging and Disability Resource Connections staff will also assist consumers with evaluating all services for which they may qualify and provide assistance with applying for those services.

Organization and Administration

Organizational Structure
The North Carolina Money Follows the Person demonstration grant will be managed by the Department of Health and Human Services. This structure will provide great coordination of services across programs as well as high-level support within the Department of Health and Human Services. The Division of Medical Assistance will have oversight responsibilities for the grant.

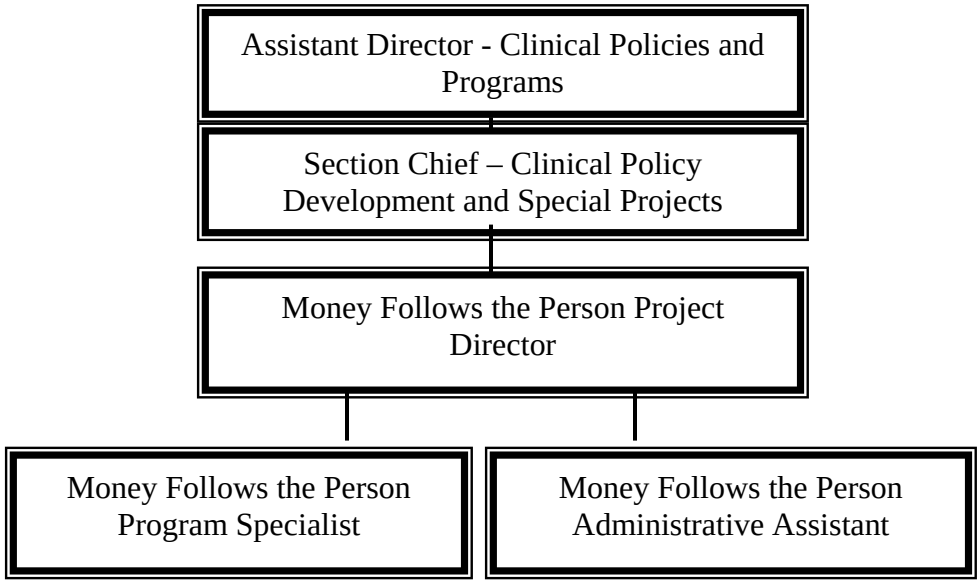
Attachment E is an organizational chart for the Money Follows the Person demonstration grant.

Staffing Plan
Project staff for the North Carolina Money Follows the Person demonstration grant will include:

a. Project Director

b. A Project Director, hired to provide direct management of the project, started in the position on February 28, 2008. The project director will be responsible for the project management, policy development, outreach development, budget management, supervision of project staff, and training and program analysis. Program Specialist
The program specialist has not been hired. It is expected this position will be filled upon approval of the State's 2008/09 budget. The person will manage the project plan and assist with project management including assisting in day-to-day program operations; serving as the liaison to the transition coordinators; and coordinating education, outreach, and training activities.

c. Administrative Assistant
The Administrative Assistant has not been hired. It is expected this position will be filled upon approval of the State's 2008/09 budget. This person will assist the Project Director and Program Specialist in administrative duties and office functions.



Billing and Reimbursement Procedures

The Medicaid Program's fiscal agent, Electronic Data Systems Corporation, is responsible for ensuring that CAP/DA, CAP/Choice, and CAP/MR-DD claims are paid correctly through a contract with the Division of Medical Assistance. Electronic Data Systems Corporation has established edits and audits in the claims payment system to ensure that payment is made in accordance with the approved methodology. Division of Medical Assistance provides oversight to the contract work performed by Electronic Data Systems Corporation.

The Program Integrity section in the Division of Medical Assistance conducts reviews to identify provider agencies who appear to be abusing or defrauding Medicaid, identifies and collects provider and recipient overpayments, educates providers and recipients when errors or abuse is detected, ensures that recipients' rights are protected, and identifies needs for policy and procedure definitions or clarifications.

Post-payment reviews by the Division of Medical Assistance look at the complete audit trail: the approval of the person-centered plan, the case manager's authorization to the provider to render approved services, service provision, service documentation, and the case manager's authorization for claims submission and actual claims data.

CAP/Choice participant files are monitored as submitted and/or changed by the Division of Medical Assistance quality assurance contractor, The Carolinas Center for Medical Excellence. Quality assurance reviews determine that participants are classified correctly at either the intermediate-care or skilled-nursing level of nursing facility care. Results of monthly monitoring are reviewed by Division of Medical Assistance CAP consultants and shared with the agencies that have been reviewed. The findings enable the agencies to improve the manner in which CAP/Choice is operated. The quality assurance review process is not a negative process, but one that leads to the strengthening of program. Additionally, The Carolinas Center for Medical Excellence looks at claims data for possible inappropriate payment of services and monthly budget monitoring.

The Resource/Regulatory Team of the Division of Mental Health/Developmental Disabilities/Substance Abuse Services also develops a monthly report that describes the services paid for waiver recipients, the number of units billed, the cost, and the number of consumers receiving each service. These data provide the ability to view services paid per individual consumer, as well as per individual Local Management Entity or provider, and may be used in the event that there is a concern or complaint received regarding a specific consumer or provider. The Division of Mental Health/Developmental Disabilities/Substance Abuse Services Accountability Team and the Division of Medical Assistance Behavioral Health Unit routinely conduct a Medicaid Compliance Audit that includes the waiver services. Auditors review Medicaid-billed events for a sample of individual directly enrolled providers. This review includes monitoring of both Division of Medical Assistance/Waiver and Division of Mental Health/Developmental Disabilities/Substance Abuse Services requirements that address staff qualifications, service authorizations, service plans, service documentation, and billing protocols. These reviews ensure that documentation and other requirements are followed for services providers bill to Medicaid and for which they are paid.

Evaluation

Evaluation is not a required component of the Money Follows the Person Operational Protocol. Although states may propose to evaluate unique design elements from their proposed Money Follows the Person programs, the state of North Carolina has opted not to include its own evaluation. The State will utilize data collected by the national evaluator (Mathematica, Inc.) for the Money Follows the Person evaluation as indicators of the project's effectiveness.

Final Project Budget

Budget Presentation and Narrative

North Carolina's budget projections for this grant are based on the anticipated enrollment of 304 individuals for the 2007-2011 project periods. The State utilized existing data and experience gained from its earlier nursing home transition grant and from its Case Management System to estimate the number of individuals that would likely be eligible under the terms of the grant. The State based its cost allocations on the uniform transition of the 304 individuals over each month of the implementation grant.

Medicaid Administrative Costs

The State has hired a full time Grant Project Director who is responsible for grant's operations. The State projects hiring a Project Program Specialist with a base salary of approximately $57,979 and the Administrative Assistant with a base salary of approximately $26,825. The two salaries include related fringe benefits of 33% for each position. In addition, the State is projecting ancillary expenditures including travel, equipment, supplies, brochures, and postage to be approximately $60,000 over the life of the grant. The State projects the total administrative expenditures to be approximately $720,161 over the life of the grant.

Qualified Home and Community-Based Services

The State also projected the 304 individuals would need to utilize more qualified Home and Community-based services due to these individuals having previously resided in a qualified nursing facility for at least a six-month period. It has been the States experience that one of the larger impediments to transitioning to the community has been a lack of community support. In response to this the state has budgeted for a larger percentage of services being utilized.

Home and Community-based Demonstration Services

The State is up-dating all CAP waivers to incorporate the new demonstration services that will be used to use to support individuals in their efforts to access services in the community.
These services are mandated to be imposed no later than March 2010. The CAP/DA services will be bundled, which are projected to be utilized by more than 50% of the Money Follows the Person target population, and will address an important gap in the State's long term system. CAP/MRDD services will be utilizes by the state and non-state ran ICFR facilities. Based on previous experience with the nursing home transition grant it is the State's experience that this service will be a resource for community services and assist with education and training of the individual community supports for those choosing to transition from the institutional setting.

Supplemental Demonstration Services

The state is projecting that a less than 10% of the individuals to be served through the Money Follows the Person grant will utilize the State's supplemental demonstration service of adaptive devices. From pervious experience the State has determined a need for adaptive devices including lift chairs, automatic door openers and other electronic assertive devices.

Money Follows the Person Budget Forms

See Attachments N, N1, N2.

Attachment A

Community Options Interest Survey: CAP/MR-DD

Guardian: _____ Resident: _____

Surveyor: _____ Date of Survey: _____

Hello. My name is _____ and I am a _____ at the _____ Center. We are calling all of the residents [**or the legal guardians**] to gather information for the Center for planning purposes. It will only take a few minutes to complete the survey. Is this a convenient time for you or would it be better to arrange another time to call back?

[**If yes, proceed with survey. If no, schedule a date and time to call again.**]

The _____ Center is committed to exploring opportunities for individuals to live in community homes with the supports they need to be safe, happy, and healthy. We want input from you as a resident [**or as _____'s legal guardian**] on your interest in community living.

If there were an option for you [**or for the individual in your guardianship**] to relocate to a community living arrangement, what circumstances or conditions would you [**or for the individual in your guardianship**] need to consider before making a decision to live in the community?

a. **The location of the community arrangement**

Community located close to family	___Yes ___No
A particular region in the state	_____
A particular county in the state	_____

b. **The type of living arrangement**

Home owned or leased by you or a family member	___Yes ___No
Apartment leased by you or a family member	___Yes ___No
Public housing	___Yes ___No
Assisted living with individual living, sleeping, bathing, and cooking areas	___Yes ___No
Community-based residence with fewer than four unrelated individuals	___Yes ___No

c. **Services and supports**

Personal emergency response services	___Yes ___No
Respite care	___Yes ___No
In-home aide services	___Yes ___No
Preparation and delivery of meals	___Yes ___No
Specialized equipment or supplies	___Yes ___No
Consumer-directed care advisory	___Yes ___No
Consumer-directed financial management	___Yes ___No
Augmentative communications	___Yes ___No
Home modifications	___Yes ___No
Non-medical transportation	___Yes ___No
Specialized consultative services	___Yes ___No
Home modifications	___Yes ___No
Vehicle adaptations	___Yes ___No
Transition expenses	___Yes ___No

d. Need immediate and consistent access to quality healthcare? ___Yes ___No

e. Behavioral supports and crisis services that meet your needs? ___Yes ___No

Surveyor's Comments:

Attachment B

DRAFT

CHOOSING WHERE YOU LIVE

North Carolina Money Follows the Person Demonstration Grant

Name of Resident_____

Name of Resident's Guardian (if applicable)_____

This a Full Guardianship__ Partial Guardianship__

Name of Surveyor:_____

Date of Survey:_____

Where Survey Conversation Occurred_____

Survey Conducted with __Resident __Guardian __Both

DID YOU KNOW YOU CAN CHOOSE WHERE YOU LIVE?

There are lots of different places you can live.

With the right kind of supports, you can live in your own place, like in a house or an apartment (sometimes with another person). You can also live in a "group home" with a few other people who use services. Living in your own home or in a group home is usually called "living in the community."

You can stay here in the _____[name of ICF-MR] but you do not have to.

We know that deciding where you live is a really big decision. No matter where you live, there will be challenges. But we think it is important for YOU to decide where you live and we want to make sure you are comfortable with whatever decision you make.

Right now, we just want you to know there are different options out there.

CHOOSING WHERE YOU LIVE SURVEY
Page 2

Where I Live (check one):

___ I really want to live in my own home or a group home. I do not want to live here anymore.

If possible, I would really like to live in:_____ [name of town or area of state].

___I'm not sure I know what part of the state I want to live in.

___I am really happy here and do not want to move right now.

___I am not sure where I want to live. I want to learn more about the different places I could live and think more about it.

How I Would Like to Learn More (check as many as you want):

___I want to talk to people who live in their own homes or group homes.

___ I want to see pictures or watch movies about people who live in their own homes or group homes.

___I want to visit people living in their own homes or group homes.

___I really want _____[person's name] to talk with me about this.

___Other Ways:

Questions I Have Right Now [Surveyor will assist in securing answers]:

Surveyor Comments:

Attachment C

North Carolina Money Follows the Person
Informed Consent Form
DRAFT

Name:	Social Security Number:

MFP is an important demonstration project that will assist NC individuals move from institutions back into the community.

You should know that:
Eligibility requirements for MFP are: reside in an institution or nursing facility for a minimum of 6 months prior transition; Medicaid eligible one month prior to transition; Move into a qualified community residence:

- A home owned or leased by the individual or the individual's family member
- An apartment with an individual lease, with lockable access and egress, and that includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control
- A residence in a community-based setting in which no more than four unrelated individuals reside

Participation includes meeting the eligibility requirements /criteria for Community Alternatives Program (CAP) waiver services or Program of All-Inclusive Care for the Elderly (PACE).

As a participant in this project, I am enrolling in a CAP waiver or Program of All-Inclusive Care for the Elderly (PACE) on the first day out of the facility/institution.

Participation in MFP is voluntary.

Participant receives demonstration services for a total of 365 days.

You can withdraw from participation in the MFP project at any time. Your case manager will have a withdrawal form for you to fill out and sign.

Participate in developing an independent living plan/plan of care with which includes goals and persons responsible for reaching the set goals. I will work in partnership with the organization to achieve my goals in the manner and time agreed upon by the staff person and me.

Participation includes acceptance of demonstration services

Supplemental supports for community living such as one-time transition expenses to enable success upon entry into the community.

You will participate in three surveys about your quality of life while living in the community

Any information collected about you will be confidential and only be used for evaluating the project

Live in the community of your choice as opposed to an institution or nursing home.

Upon conclusion of 365 days in MFP project, you may continue with CAP waiver services so long as the level of care assessment conducted annually indicates a continued need.

If re-institutionalized for more than 30 consecutive days, you will be reevaluated for continued MFP eligibility and have an updated Plan of Care. If after three incidences/occurrences of re-institutionalization of 30 consecutive days or longer, you will no longer be considered for reentry into the Money Follows the Person project.

If you do not join the project, you can still receive Medicaid 1915(c) waiver services as long as you meet the eligibility requirements.

You will be provided information about MPF. You will be provided an opportunity to review this information and have your questions answered.

Right to appeal as per the CAP Waiver or Program of All-Inclusive Care for the Elderly (PACE) in which enrolled.

Complaints:
Contact: The Department of Health and Human Services Ombudsman Program was created to address inquiries and complaints that consumers and their legal/guardians have regarding services that Department of Health and Human Services oversees or administers. The Regional Long Term Care Ombudsmen program can also be accessed through the CARE-LINE and is available 24 hours a day/7 days a week, by calling 1-800-662-7030 (English/Spanish) or 1-877-452-2514 (TTY).

Consent:
My signature below indicates the following:

I have received information about MFP;

My questions about the MFP project have all been answered to my satisfaction;

I acknowledge my understanding of the MFP project; and

I accept to participate in the MFP project, if I am determined eligible;

MFP Participant Acknowledgement
Participant Signature:
Date Signed:
Mailing Address:
City, State, ZIP
Telephone No.:
Guardian/Legal representative Acknowledgement (if applicable)
Guardian/Legal Representative Signature:
Date Signed:
Mailing Address:
City, State, ZIP
Telephone No.:
Case Manager Acknowledgement
I have read and explained this document to the applicant. I believe that he/she (or the guardian/legal representative , if signed) understood this document.
Signature:
Date Signed:
Mailing Address:
City, State, ZIP
Telephone No.:
Witness Signature, if applicable (if X'd)
Signature:
Date Signed:
Mailing Address:
City, State, ZIP
Telephone No.:

Attachment D

The North Carolina Department of Health and Human Services, Division of Medical Assistance (DMA) Introduces…

The *Money Follows the Person Demonstration Grant project*!

What does "Money Follows the Person" mean?
When people who are elderly or have disabilities need personal assistance, they often have to go to a nursing home or an institution in order for Medicaid to pay for it. However, many folks would prefer to receive these services in their own homes and in their own communities.

Money Follows the Person is the term describing the practice of Medicaid allowing these same people to move *out* of nursing homes and institutions and receive the assistance they need to live in their homes and communities. Thus, the **money** for the assistance **follows** the **person** out of the nursing home or institution and into their homes and communities.

Why is this called a "Demonstration Project?"
The federal government is awarding extra funding and assistance to states wishing to **demonstrate** how state Medicaid agencies can effectively develop "Money Follows the Person" practices. This funding is time-limited and each state must agree to move people from institutional settings to home and community-based settings.

North Carolina was awarded its Money Follows the Person Demonstration Grant in May 2007.

What is the purpose of North Carolina's Money Follows the Person Demonstration Grant Project?
Reorganizing Medicaid services to enable **money** to **follow** people out of institutions is a very complex process. It involves shifting state policies, rules and regulations, adjusting Medicaid funding streams, and supporting local communities so people who are elderly or have disabilities can come home.

The purpose of the Money Follows the Person Demonstration Grant is to provide the state with additional funding and support so it can assist 304 people to move from institutional settings to home and community-based settings and also ensure this continues after the grant ends.

Who will benefit from the Money Follows the Person Demonstration Grant project?
During the course of the Project, North Carolina wants to support **at least** 304 people who are currently in nursing homes or institutions to move from institutional care to

home and community-based services. These people will be made up of senior citizens, people with developmental disabilities, people with physical disabilities and people with mental illness.

How long will Money Follows the Person Demonstration Grant project last?
Until September 30, 2011.

What happens when the Money Follows the Person Demonstration Grant project is over?
Hopefully, the state will have the structures and supports in place to begin supporting **anyone** who is eligible to receive services in a nursing home or institution to receive those same services in their homes and communities.

How is Money Follows the Person Demonstration Grant project different from other Money Follows the Person advocacy efforts in North Carolina?
In addition to North Carolina's Money Follows the Person Demonstration Grant project, there is also a Money Follows the Person grass-roots advocacy effort. This grass-roots advocacy effort is promoting *state legislation* that will allow anyone who is eligible to receive personal care in a nursing home or institution to receive those same services in their homes and communities. The Money Follows the Person Demonstration Grant project *(a federally funded initiative)* targets 304 people in North Carolina, while the Money Follows the Person grassroots effort is advocating for everyone to have this option.

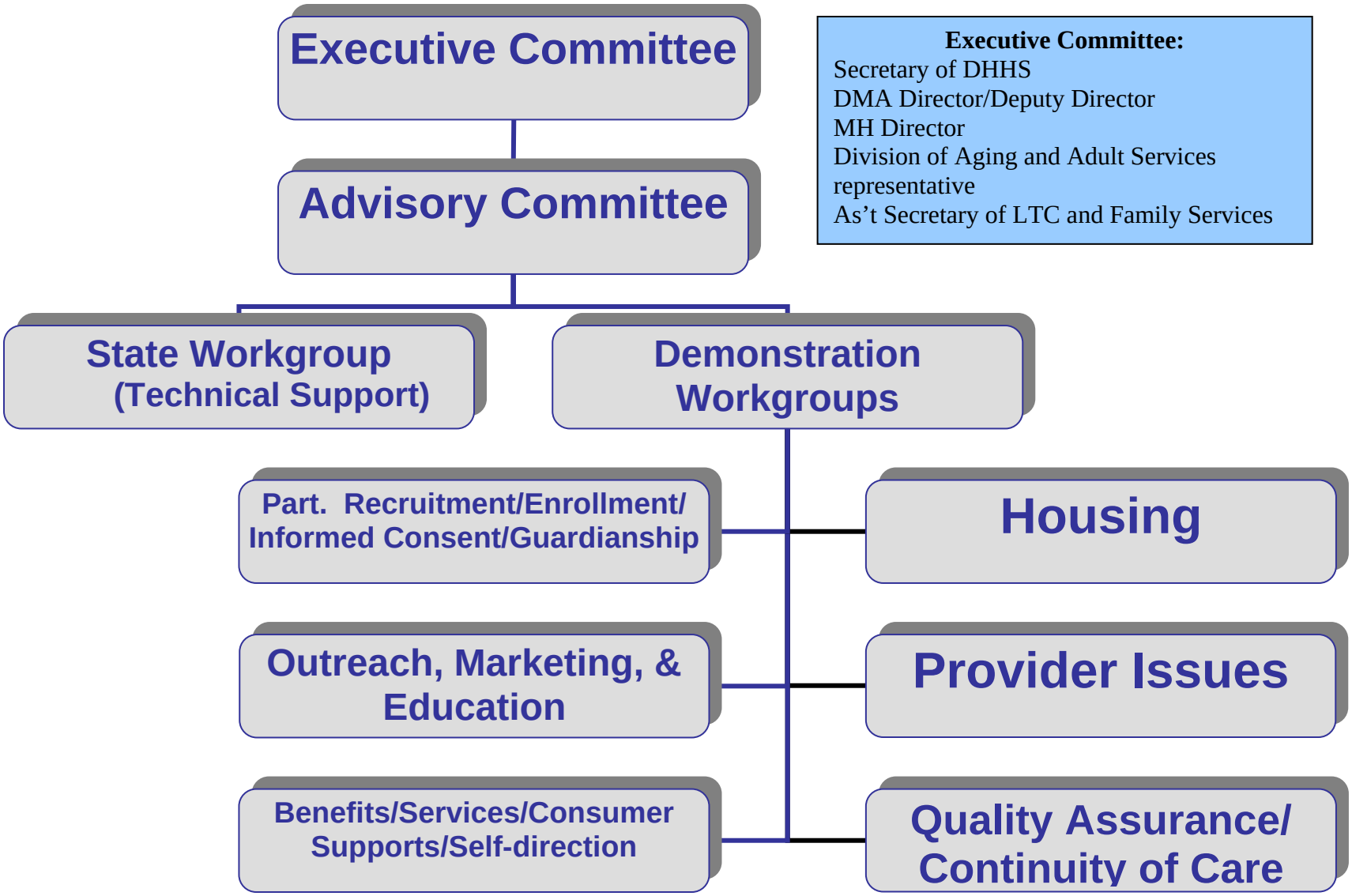
The two efforts have the same goal: to support people to live in their homes and communities.

Who do I contact if I want more information on the Money Follows the Person Demonstration Grant project?
Linda Hicks, Project Director
919-855-4260 or linda.m.hicks@ncmail.net

Is there a website where I can learn more about North Carolina's Money Follows the Person Demonstration Grant project?
North Carolina Division of Medical Assistance has created a site for the Money Follows the Person Demonstration Grant project. Please visit http://www.ncmfp.com.

The North Carolina Disability Action Network (NCDAN) is following the Money Follows the Person Demonstration Grant project's progress and has lots of useful information including a link to the site above. NCDAN's website: www.ncdan.com

Attachment E



Executive Committee:
Secretary of DHHS
DMA Director/Deputy Director
MH Director
Division of Aging and Adult Services representative
As't Secretary of LTC and Family Services

Each Demonstration workgroup has a State and non-State employee facilitator and is composed of providers and consumers.

Attachment F
(Opening page of NCcareLINK website)

- • Text Size: Small Change
- • Help
- • Contact Us

NC careLINK

- Home
- Search By Keyword
- Search By Topics
- My NCcareLINK

Welcome to North Carolina's careLINK

A comprehensive health and human services web site.

This website provides up-to-date information about programs and services across North Carolina for families, seniors, youths and everyone in-between. It is a collaborative effort of the North Carolina Department of Health and Human Services and many other government and non-profit information and referral stakeholders across North Carolina. Click the Start a Search button to get started.

Neighborhoods


Services for Veterans

The Veterans and their Families Resources Neighborhood is a statewide link to assist veterans and their families find a variety of programs. This section can assist the veteran in finding services including Veterans Benefits Assistance, Financial Assistance, Hospital and Medical Services, Counseling Services and other veteran related services.


Family and Children Resources

The Family and Children Resources Neighborhood is a statewide link to help you meet the wide spectrum of needs of your children or family. This section of NCcareLINK will help you connect to resources that will allow you and your family to achieve self sufficiency. You will be able to link to a variety of services including resources for day care, medical care, education, child support, adoption and foster care, assistance with food and clothing needs and much more.

 Services for Older Adults

The Services for Older Adults Neighborhood of NCcareLINK will help seniors, their families, and caregivers focus on finding the help they need. This is your direct link to a variety of services including: adult day care programs and nursing homes, employment, family and caregiver support programs, health, housing and long term care options.

 People with Disabilities Connection

The People with Disabilities Connection Neighborhood is a statewide link to resources and services. This is your connection to a variety of resources that will help you in achieving equal access, effective communication and a better quality of life. Some services include supports for living independently, residential care, communication and technology, community advocacy and employment.

Take Me To . . .

Find My Vet Center

Vet Centers provide readjustment counseling and outreach services to all veterans who served in any combat zone. Services are also available for their family members for military related issues. Veterans have earned these benefits through their service and all are provided at no cost to the veteran or family.

Provider Portal

The provider portal section allows resource providers access to their existing information for updating purposes. The provider portal also allows new resource providers to add their information and to become an essential resource to the community. Click on the "Provider Portal" link above to go there.

Partners Page

NCcareLINK is a collaboration of partners throughout North Carolina that provide the most current resource information. Click to visit the NCcareLINK partner's page.

Easter Seals UCP North Carolina

Sign In to Save Resources

If you are already a registered user, sign in below. If you'd like to register, go to the registration page.

Note: User ID and Password are case-sensitive.

User ID Password Sign In Remember Me

Forgot Your Password?

Forgot Your User ID?

Need to Register?

How We Protect Your Privacy

Opening page for link to People with Disabilities Connection

on NCcareLINK resource website

- Home
- Search By Keyword
- Search By Topics
- My NCcareLINK

People with Disabilities Connection

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Popular Search Topics

- Caregiver Supports
- Chemical & Mental Health
- Communications
- Education
- Employment
- Financial
- Food
- Health Services & Equipment
- Home and Community Living
- Housing
- Legal & Advocacy
- Leisure
- Long Term Care Ombudsman
- Public Benefits
- Technology & Modifications
- Transportation & Driving

Take Me To . . .

NCcareLINK Main Page

Online access to statewide community resources.

Find My Vet Center

Vet Centers provide readjustment counseling and outreach services to all veterans who served in any combat zone. Services are also available for their family members for

military related issues. Veterans have earned these benefits through their service and all are provided at no cost to the veteran or family.

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CUMBERLAND COUNTY PUBLIC LIBRARY & INFORMATION CENTER

Sign In to Save Resources

If you are already a registered user, sign in below. If you'd like to register, go to the registration page.

Note: User ID and Password are case-sensitive.

User ID Password Sign In Remember Me

Forgot Your Password?
Forgot Your User ID?
Need to Register?
How We Protect Your Privacy

- Legal
- Privacy
- Disclaimer
- Accessibility Policy
- Accessibility Tips
- Technical Problems
- General Info
- Satisfaction Survey

Attachment G

Self-Direction

I. Participant Centered Service Plan Development

a. **Responsibility for Service Plan Development**. Specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

X	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
X	Case Manager. *Specify qualifications*:
X	Social Worker. *Specify qualifications:*
	Social Worker I or higher as specified by the North Carolina Office of State Personnel. Social Worker I requires a bachelor's degree n a human services field from an accredited college or university; bachelor's degree from an accredited college or university and one year directly related experience.
☐	Other (*specify the individuals and their qualifications):*

b. Service Plan Development Safeguards. *Select one:*

○	Entities and/or individuals that have responsibility for service plan development *may not provide* other services to the participant.
X	Entities and/or individuals that have responsibility for service plan development *may provide* other direct services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:
	All lead agencies have a freedom of choice policy and freedom of choice documents that are required to be signed by participants after plan of care development is completed. These documents explain the participant's choice to choose from any qualified provider for their traditional services at any time, upon request. Additionally, participants in this waiver have the extra responsibility of choosing and directing other specific waiver services (e.g. personal assistant, respite, supplies, etc.). A backup plan is developed to assure that the needed assistance will be provided if any key supports identified in the plan are temporarily unavailable. Participants are also informed of due process rights if they disagree with any decisions made by the care advisor. Consultants from Division of Medical Assistance conduct agency reviews and review plans. Additional monitoring of services is given in situations where the entity providing care advisement also provides another waiver service. This occurs sometimes in more rural regions of North Carolina.

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The care advisor assists the participant in assessing individual needs and developing a plan of care including a participant-directed budget. The care advisor provides orientation and training on participant-directed care to the participant and/or participant's representative or family members as appropriate. The care advisor monitors the provision of care and expenditures and maintains contact with the participant to assure the needed care is being provided. The care advisor is also responsible for identifying the need for a representative and assuring that representatives are capable of meeting the needs of the participant.

The role of participants is greater in CAP/Choice than in the traditional program CAP/DA. In CAP/CHOICE participants have more control over resources. With this increased control comes increased responsibility. The key responsibilities of the participant or designated representative are:

- Develop a plan of care with assistance/support from the care advisor;
- Recruit, hire, and manage personal assistant and other individual providers of participant-directed services;
- Prepare an outline of duties and work schedule for personal assistant;
- Negotiate salary and benefits with the assistant;
- Notify assistant of any changes in schedule in a timely manner;
- Train and evaluate personal assistant;
- Negotiate reimbursement or payment rates with individual providers;
- Develop a back-up/emergency plan (alternative caregivers);
- Serve as employer of record for personal assistant;
- Verify accuracy of documentation or provide documentation, as appropriate, to financial manager regarding services provided;
- Report concerns to care advisor about service delivery or representative that affect health and well-being; and,
- Uphold all program agreements as written.

d. Service Plan Development Process In three pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how the MFP demonstration and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) assurance that the individual or representative receives a copy of the plan. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a)The following individuals are responsible for the preparation of the plans of care:
The Participant and the care advisor.

(b)A registered nurse and social worker team meet with the applicant/significant others to conduct an assessment and determine the need for a representative.

(c)During the intake process, a care advisor or case manager knowledgeable of participant-directed care provides information on both the traditional and participant-directed care program and the applicant decides which program he/she wishes to pursue.

(d) The plan of care and supporting documents are reviewed by and approved by someone at the lead agency other than the care advisor, after agreement and signature by the participant and/or representative and care advisor. Focus is on the ability to meet the identified needs of the participant within the budget limitations whilst maintaining the participant's health, safety and well-being.

The contracted Quality Assurance/Quality Improvement agency, as well as Division of Medical Assistance consultants, is able to perform ongoing review of plans of care as well as more in-depth reviews on site monitoring visits.

(e)The care advisor assists the applicant in developing a plan of care including both unpaid and paid services, and calculates the participant budget according to state requirements.

(f)The care advisor will assist with development of plan of care and emergency/back-up plan; provide information and skills training to participant/participant's representative; provide worker orientation to participant-directed care; monitor plan of care for quality assurance purposes.
Also, waiver program consultants from the State Medicaid agency conduct annual, on-site program reviews and assist/advise with local operation of the waiver program as needed.

(g) Plans of care are updated as many times as warranted by a change in health status, need, etc. However, re-evaluations of the level of care are required at least annually or sooner if there are indications that the participant's condition/level of care has changed. A new assessment and plan of care are required at the same time as the annual level of care re-evaluation.

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The state has procedures to promote family or individual preferences and selections. These are appropriately balanced with accepted standards of practice. This balance requires deference to the preferences of the individual whenever possible. Procedures may include individual risk management planning (e.g., risk agreements or informed consent contracts) to ensure that family or individual decisions are honored.

Participants and/or designated representative will be fully involved in the needs assessment process and will select personal assistants based on their (vs. agency) preferences. The participant will train the assistant and determine whether task competencies are met. In assuming these responsibilities, the participant necessarily takes on risk that was previously assumed by provider agencies and program managers. Participants who participate in this program will therefore enter into agreements with the lead agencies which outline rights, risk and responsibilities.

A back-up plan is also developed to assure that the needed assistance will be provided if any key supports identified in the Plan are temporarily unavailable. The Care Advisor provides the information and skills training needed to manage one's own care in the areas of rights and responsibilities of both the Consumer and Worker; recruiting and hiring workers; developing schedules and outlining duties; supervising and evaluating workers; reporting on personal assistance expenditures; and other relevant information and training.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the services in the service plan.

The care advisor is available to the participant throughout the planning and service delivery process to provide skills training and information relevant to home care, worker employment, etc. The amount of assistance from the advisor will vary from participant to participant depending upon need. Care advisors are to make available to the participant a comprehensive list of qualified providers in, or having the ability to provide services in the applicable service area. This list will be made available upon the participant's or the representative's request.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency or other agency operating the MFP demonstration project:

The same basic care planning process currently used in the elderly/disabled Home and Community Based Services waiver, CAP/DA, will apply to CAP/Choice with the addition that the process will be guided by principles of participant-directed care. Currently the steps in the entry process are:
1.During the intake process, a care advisor or case manager knowledgeable of participant-directed care provides information on both the traditional and participant-directed care program and the applicant decides which program he/she wishes to pursue;
2.A health care professional along with the planning team meet with the applicant/significant others to conduct an assessment and determine the need for a representative;
3.The care advisor assists the applicant in developing a plan of care including both unpaid and paid services, and calculates the participant budget;
4.The care advisor submits the plan to the designated position in the lead agency for approval.
5.Once approval is obtained, services are implemented by the care advisor or participant, as specified in the plan; and,
6.Post-approval reviews by Carolinas Center for Medicaid Excellence quality assurance processes and Division of Medical Assistance consultants are conducted as requested or Plan is sent to Division of Medical Assistance.

h. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for the duration of time that the state is operating the Money Follows the Person project plus one year. For example, if the state enrolls individuals into the MFP program for three years the state must retain all service plans for four years time (the three years of the demo plus one additional year.) Service plans are maintained by the following *(check each that applies)*:

☐	Medicaid agency
☐	Operating agency
☐	Case manager
X	Other (*specify):*
	Lead agencies in each county. Note: due to the current use of the AQUIP, an automated assessment and plan of care system, the Division of Medical Assistance has access to electronic records via a secured website at any time.

II. Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a)Care advisors and CAP/Choice program consultants ensure that waiver services are furnished in accordance with the plan of care by maintaining regular contact with the participant and/or designated representative. Monthly contact is required via telephone and/or home visit. Home visits are required a minimum of quarterly. (b) & (c)Method and Frequency of Oversight/Monitoring: Waiver program consultants from the State Medicaid agency conduct annual, on-site program reviews and assist/advise with local operation of the waiver program as needed. These visits occur every 12-18 months.

b. Monitoring Safeguards. *Select one:*

○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
X	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:
	(a)Adequate standards for all types of providers that furnish services under the waiver. (b)Assurance that applicable state licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements will be met on the date that the services are furnished. (c)Assurance that all facilities covered by Section 1616(e) of the Social Security Act, in which Home and Community-Based Services will be provided, are in compliance with applicable State standards for board and care facilities. Participants are provided the freedom of choice amongst providers and are educated on all due process rights. Division of Medical Assistance consultants provide technical assistance and review this information on request and/or at program site visits.

III. Overview of Self-Direction

a. Description of Self-Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the demonstration, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the demonstration's approach to participant direction.

(a)Under CAP/Choice, participants will be able to:
• Choose (hire) the personal assistant who will provide their care;
• Train, supervise and evaluate the worker;
• Negotiate the rate of pay and other benefits;
• Release the worker should this become necessary;
• Select individual providers and direct reimbursement for several other waiver services (identified previously in Appendix C-1/C-3 of the waiver amendment); and,
• Engage in a cooperative working arrangement with a financial manager who will pay the client's worker, handle federal/state taxes and other payroll or benefits related to the employment of the worker, and reimburse other service providers under the direction of the participant.

(b)The program affords increased participant choice and independence in meeting home care needs and increasing satisfaction with long term supports. To be eligible for CAP/Choice an individual must:
• Live in the geographic areas where CAP/Choice is available;
• Meet basic criteria to be assessed for home and community based services waiver participation e.g., at risk of institutional care;
• Be eligible for Medicaid; and,
• Understand the rights and responsibilities of directing one's own plan of care and be willing and able to self-direct or select a representative who is willing and capable of assuming this responsibility

(c)Division of Medical Assistance, Local Lead Agencies, Financial Management Agencies, Waiver Service Providers and other providers interacting with and participating in the participant's plan of care.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the demonstration. *Select one:*

○	**Participant—Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide demonstration services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
○	**Participant—Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for demonstration services. Supports and protections are available for participants who have authority over a budget.
X	**Both Authorities.** The demonstration provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

X	Participant direction opportunities are available to participants who live in their own private residence (whether owned or leased) or the home of a family member.
☐	Participant direction opportunities are available to individuals who reside in other community-based living arrangements where services (regardless of funding source) are furnished to four or fewer persons unrelated to the proprietor.
☐	The participant direction opportunities are available to persons residing in a leased apartment, with lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual or individual's family has domain and control.

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect one):*

X	The demonstration is designed to afford every participant (or the participant's representative) the opportunity to elect to direct demonstration services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	The demonstration is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

(a)Under CAP/Choice, participants will be able to:
•Choose (hire) the personal assistant who will provide their care
•Train, supervise and evaluate the worker
•Negotiate the rate of pay and other benefits
•Release the worker should this become necessary
•Select individual providers and direct reimbursement for several other waiver services
•Engage in a cooperative working arrangement with a financial manager who will pay the client's worker; handle federal/state taxes and other payroll or benefits related to the employment of the worker; and reimburse other service providers under the direction of the participant

(b)The lead agency will give each Home and Community Based Services waiver applicant a choice between the traditional program and the new participant-directed model. In making this decision a participant/representative will be educated on the benefits and responsibilities of the participant-directed model.

(c)The care advisor provides orientation and training on participant-directed care to the participant and/or participant's representative or family members as appropriate prior to implementation of participant-directed services. The advisor monitors the provision of care and expenditures and maintains contact with the participant to assure that the needed care is being provided on a continuing basis. Care Advisors will participate in training and have access to materials with a participant-directed focus.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of demonstration services by a representative *(select one)*:

○	The State does not provide for the direction of demonstration services by a representative.	
X	The State provides for the direction of demonstration services by a representative. Specify the representatives who may direct demonstration services: *(check each that applies)*:	
	X	Demonstration services may be directed by a legal representative of the participant.
	X	Demonstration services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of demonstration services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:
		The representative may NOT also be the paid caregiver (i.e. personal assistant) for the participant. The representative cannot be paid for the service and must meet the following requirements: • demonstrate knowledge and understanding of the participant's needs and preferences; • agree to a predetermined level of contact with the participant; • be willing to comply with program requirements; • be at least 18 years of age; and, • be approved by the participant to act in this capacity. The Care Advisor plays a significant role in identifying the need for a representative and assuring that the representative meets the criteria outlined above. Additionally, the care advisor, as part of ongoing monitoring activities, assures that the representative continues to act in the best interest of the participant.

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each demonstration service. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Demonstration Service	Employer Authority	Budget Authority
Respite Services (In-Home)	X	X
Financial Management Services	X	X
Home Modifications and Mobility Aids	X	X
Consumer-Directed Goods and Services	X	X
Personal Assistant Services	X	X
Waiver Supplies	X	X

h. Financial Management Services. Generally, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the demonstration participant. *Select one:*

X	**Yes**. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:*	
	X	Governmental entities
	X	Private entities
○	**No**. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*	

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a demonstration service or as an administrative activity. S*elect one*:

X	FMS are covered as a Demonstration service		Fill out i. through iv. below:
○	FMS are provided as an administrative activity. Fill out i. through iv. below*:*		
	i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:	
		Fiscal Employer Agency	
	ii.	**Payment for FMS**. Specify how FMS entities are compensated for the activities that they perform:	
		FM is billed in units of 15 minutes. FM is allowed to bill up to 6 units for the startup month and up to 4 units per month thereafter. Total units in a year cannot exceed 50.	
	iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*	
		Supports furnished when the participant is the employer of direct support workers:	
		X	Assist participant in verifying support worker citizenship status
		X	Collect and process timesheets of support workers
		X	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
		X	Other *(specify):*
			Financial Management Services are provided to assure that participant-directed funds outlined in individual plans of care are managed and distributed as intended. The Financial Manager files claims through the MMIS for participant-directed goods and services and reimburses individual providers. The FM deducts all required federal, state and local taxes, including unemployment fees, prior to issuing reimbursement or paychecks. The Financial Manager entity is responsible for maintaining separate accounts on each participant's services funds and producing expenditure reports as required by the State Medicaid agency. The Financial Manager also provides reports on at least a monthly basis to the participant. The Financial Manager conducts criminal background checks and age verification on personal assistants as requested by the participant.

		Supports furnished when the participant exercises budget authority:	
		X	Maintain a separate account for each participant's self-directed budget
		X	Track and report participant funds, disbursements and the balance of participant funds
		X	Process and pay invoices for goods and services approved in the service plan
		X	Provide participant with periodic reports of expenditures and the status of the self-directed budget
		☐	Other services and supports *(specify)*:
		Additional functions/activities:	
		X	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
		☐	Other *(specify):*
	iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of Financial Manager Services entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.	

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the demonstration:*	
X	**Demonstration Service Coverage**. Information and assistance in support of participant direction are provided through the demonstration service coverage (s) entitled:	**Care Advisory, Financial Management Services**

☐	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the demonstration; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

k. Independent Advocacy *(select one)*.

X	**Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:
	1) North Carolina's Long Term Care Ombudsman Program consists of state and regional ombudsmen who help residents of long-term-care facilities to exercise their rights. In addition to being an advocate for residents, they educate the public and facility staff about rights and help resolve grievances between residents/families and facilities. The regional ombudsmen, who are located within Area Agencies on Aging, also help support the efforts of Adult Care Home and Nursing Home Community Advisory Committees (N.C.G.S. 131E-128 and 131D-3). These local committees, which are composed of volunteers appointed by county commissioners, routinely visit facilities, serve as advocates for residents, help ensure that the intent of the resident's bill of rights is maintained, and work to increase community involvement in long-term-care facilities. There are over 1,100 such volunteers statewide, with committees in each county. The services provided by the Ombudsman Program include: A. Answering questions and giving guidance about the long term care system. An ombudsman will: • explain long term care options. • give pointers on how to select a long-term-care facility provide information on specific facilities (such as the latest and past certification reports and complaint information). • explain residents' rights and other federal and state laws and regulations affecting long-term-care facilities and residents. • give guidance on the Medicaid and Medicare programs--specifically qualification criteria, application procedures and what services these programs cover. • give guidance on such matters such as powers of attorney, living wills and guardianship. B. Educating community groups and long term care providers on various topics such as residents' rights, restraint use, care planning, activities and new laws.

	C. Investigating and assessing matters to help families, residents and families resolve concerns and problems. Common areas of complaints include: • medical and personal services being provided to residents such as problems with medication, nutrition and hygiene. • financial concerns such as handling of residents' funds, Medicare, Medicaid, and Social Security. • rights of residents, such as the right to be treated with courtesy and to have individual requests and preferences respected. • nursing home administrative decisions, such as admission to or discharge from a facility. D. Working with appropriate regulatory agencies and referring individuals to such agencies when resolutions of issues are not possible through the Ombudsman Program alone. E. Raising long term care issues of concern to policymakers. 2) County Adult Protective Service programs are required to investigate and act upon any allegations of abuse, neglect, and exploitation of the participant. 3) The participant has the opportunity to self-advocate through participation in local non-profit advocacy groups, such as Centers for Independent Living, the Participant Task Forces of various state programs and initiatives (e.g. - Rebalancing Grant, Money Follows the Person Demonstration, Systems Transformation Grant, etc), and input into the State Independent Living Council.
○	**No.** Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

A Care advisor works with the participant to transfer to an alternate waiver or other state plan service(s) and monitors health and safety until the new service is fully implemented.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Plans of care and service provision will be continually monitored by the care advisor to see that needs are met and funds are utilized according to program criteria. If problems in these areas are identified, the care advisor will work with the participant to resolve them. If they cannot be resolved, the participant will be removed from the program and assessed for the traditional home and community based services program, CAP/DA. Care advisors/lead agencies will consult with Division of Medical Assistance program consultants prior to taking any action.

Participants who demonstrate the inability to self-direct waiver services, whether due to misuse of funds, consistent non-adherence to program rules, or an ongoing health and safety risk, will be required to select a representative to assist them with the responsibilities of self-direction. If a participant refuses to select a representative or if participant loses a representative and cannot locate a replacement, they will be required to transfer to another waiver program that has traditional agency oversight. Care advisors will assist the participant in the transition. Participants are given due process rights for any changes in service and/or termination/removal of a service/program.

Note: Participants may also voluntarily terminate participant direction in favor of returning to CAP/DA.

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the demonstration is in effect for the unduplicated number of demonstration participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their demonstration services.

Table E-1-n

	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Demonstration Year	**Number of Participants**	**Number of Participants**
Year 1 (2008)		0
Year 2 (2009)		2
Year 3 (2010)		2
Year 4 (2011)		1
Year 5		N/A

Participant Employer

a. Participant—Employer Authority *(Complete when the demonstration offers the employer authority opportunity as indicated in Item E-1-b)*

i. Participant Employer Status. Specify the participant's employer status under the demonstration. *Check each that applies:*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide demonstration services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. *Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:*

X	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide demonstration services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide demonstration services. *Check the decision making authorities that participants exercise*:

X	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
☐	Select staff from worker registry
X	Hire staff (common law employer)
X	Verify staff qualifications
X	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
	The financial manager does this upon request of the participant. The cost is incorporated into the financial management reimbursement.
X	Specify additional staff qualifications based on participant needs and preferences
X	Determine staff duties consistent with the service specifications
X	Determine staff wages and benefits subject to applicable State limits
X	Schedule staff
X	Orient and instruct-staff in duties
X	Supervise staff
X	Evaluate staff performance
X	Verify time worked by staff and approve time sheets
X	Discharge staff (common law employer)
☐	Discharge staff from providing services (co-employer)
☐	Other *(specify)*:

b. Participant—Budget Authority *(Complete when the demonstration offers the budget authority opportunity as indicated in Item E-1-b)*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply***:**

X	Reallocate funds among services included in the budget
X	Determine the amount paid for services within the State's established limits
X	Substitute service providers
X	Schedule the provision of services
X	Specify additional service provider qualifications
X	Specify how services are provided,
☐	Identify service providers and refer for provider enrollment
X	Authorize payment for demonstration goods and services
X	Review and approve provider invoices for services rendered
☐	Other *(specify):*

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for demonstration goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Methodology for Calculation of Individual/Participant-Directed Budget:

Budgets will be calculated based on the methodology in place for the CAP/DA waiver currently serving the elderly/disabled. The process involves an assessment to identify needs; development of goals based on identified needs; and agreement on the type and amount of services needed to meet the goals. The estimated monthly cost of each service is calculated. The cost of all services cannot exceed the average per capita cost to Medicaid of nursing facility care. Additionally, there is monthly individual budget limit, designated by level of care that cannot be exceeded.

The budget will contain both agency and participant-directed services, as outlined below. Those designated as participant-directed will constitute the individual budget to be directed by the participant.

Agency-Directed:
Adult Day Health Care
Care Advice
Financial Management
In-Home Aide
Institutional Respite
Preparation & Delivery of Meals
Telephone Alert

Participant-Directed:
Participant-Designated Goods & Services (additional limit of $600/year)
Home Modifications and Mobility Aids* (additional limit of $1500/year)
Personal Assistant
Respite (In-Home)
Waiver Supplies*
*Indicates service may be either participant or agency directed

It is recognized that actual utilization of services authorized does not equate to 100%—for example, participants are hospitalized, aides miss visits and substitutes are not available. (*North Carolina Division of Medical Assistance requires a minimum of monthly monitoring of all waiver services, including the participant's emergency back-up plan. If it is determined the participant's needs are not being met the plan of care is modified to address these needs. New supports and services are identified and put in place to meet these needs. If these needs continue to go unmet or the participant's health and well-being are at risk other programs may be identified that better serve the participant.) Based on findings of the National Cash & Counseling Demonstration, at least 10 to 20% of personal care services authorized in the traditional delivery system is not used. In addition, many of the indirect costs which are built into the payment rates such as professional supervision and training of workers, office space, equipment, supplies, etc., are not applicable to the participant-directed model. Therefore, the maximum hourly rate for personal assistant services will be 10 to 20 percent lower than the current Medicaid personal care rate. Individuals may negotiate personal assistant payment rates lower than the maximum, thereby enabling them to set aside a portion of their budget for other services such as participant-designated goods and services which would increase independence.

Participants will have considerable flexibility in using funds designated as participant-directed. They will be able to substitute services and/or reschedule services within the budget without agency approval in certain cases.

The methodology will be explained to the participant/representative by the care advisor. The care advisor will point out both the added responsibilities if this model is selected and its benefits. The Individual/Participant-Directed Budget will be re-determined at least annually and more frequently depending on changes in the Participant's situation. The methodology will be published in the operations manual for this program. All Medicaid policy and program manuals are available for public inspection.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The participant must be informed of the amount of the individual budget during and after the service plan development process. Participants may inquire about the balance of their account throughout waiver enrollment from his/her care advisor in addition to an annual evaluation.

iv. Participant Exercise of Budget Flexibility. *Select one:*

X	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
	Participants have the authority to modify the timing of service delivery (ex. personal assistant hours). Otherwise, modifications to the participant-directed budget must be preceded by a change in the service plan after discussion with the care advisor.
○	Modifications to the participant-directed budget must be preceded by a change in the service plan.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

At the local level plans of care and service provision will be continually monitored by the care advisor to see that needs are met and funds are utilized according to program criteria. If problems in these areas are identified the care advisor will work with the participant to resolve them. If the problem(s) is not resolved, care advisors/local lead agencies will consult with Division of Medical Assistance program consultants prior to taking any adverse action towards a participant.

Additionally, post-approval and post-payment reviews are conducted by Carolinas Center for Medicaid Excellence and Division of Medical Assistance consultants.

Attachment H

North Carolina Division of Medical Assistance
Quality Management Strategy for Money Follows the Person
For Persons Enrolled in CAP/DA and CAP/CHOICE Waiver Programs

June 12, 2008

I. Introduction and Purpose

The North Carolina Community Alternatives Program for Disabled Adults (CAP/DA) is a home and community-based 1915(c) waiver program managed by the Facility and Community Care Section of the North Carolina Division of Medical Assistance (DMA). The CAP/DA Program provides a package of services and supports that allows adults who are elderly or disabled and who qualify for nursing facility care to remain in their private residences. Services include:

- Case management;
- Adult Day Health;
- In-home personal care aide services;
- Home mobility aids;
- In-home and institutional respite care;
- Preparation and delivery of meals;
- Waiver supplies, such as nutritional supplements and incontinence supplies; and
- Telephone response system.

CAP/DA participants can also receive regular Medicaid services, such as hospital care, physician services, home health care, DME, hospice, home infusion therapy, and private duty nursing. These services are provided under program guidelines to ensure there is no duplication of care and services. In State Fiscal Year 2007, the CAP/DA Program served 14,485 non-duplicated Medicaid recipients in all 100 North Carolina counties. On a monthly basis, CAP/DA served an average of 11,512 individuals who require long-term care services and supports to remain in their homes and communities. The CAP/DA Program is the major source of Medicaid assistance for individuals transitioning out of nursing facilities into community care. Plans are being made to redesign this program to provide a broader range of services and supports to support the Money Follows the Person Demonstration Project, including paying for one-time transition expenses.

The overall purpose of the Quality Improvement Strategy (QIS) for CAP/DA is to design, develop, implement, and manage a Quality Assessment and Quality Improvement Program for CAP/DA that:

1. Ensures that the Division of Medical Assistance meets the Centers for Medicare and Medicaid Services' (CMS) assurances for the Money Follows the Person Rebalancing Demonstration and the CAP/DA waiver renewal;
2. Implements the CMS Quality Framework in a manner that will meet all CMS requirements and assurances for waiver services;
3. Establishes a systematic approach to monitor, evaluate, and continuously improve the quality of CAP/DA services;

4. Identifies and sets appropriate performance and outcome measures to evaluate CAP/DA services; and
5. Implements a Quality Management (QM) Program for CAP/DA that focuses on participant-centered outcomes related to:
    a. Participant access;
    b. Participant-centered services planning and delivery;
    c. Provider capacities and capabilities;
    d. Participant safeguards;
    e. Participant rights and responsibilities;
    f. Participant outcomes and satisfaction; and
    g. System performance.

II. Quality Management Strategy

The CAP/DA Quality Management Strategy is based in part on the CMS Quality Framework and CMS Regional Waiver Review Protocol. Major components include Design, Discovery and Data Sources, Remediation, and Continuous Improvement. Each is described below:

Design

Program design sets the stage for achieving the desired outcomes for the CAP/DA Program for CAP/DA enrolled participants. Design features include:

a. Identifying indicators and standards against which performance is measured;
b. Developing an approach to collect, synthesize, and share performance information; and
c. Develop a cohesive work plan that directs time, effort, and resources into the process.

CAP/DA's program design, as outlined in this Quality Management Strategy, addresses such topics as level of care determinations, service planning, provider qualifications, monitoring participant health and welfare, administrative authority of the program, and financial accountability.

Discovery Sources and Data Sources

In this process, CAP/DA data and direct participant experiences are collected to assess the ongoing implementation of the program and identify strengths and opportunities for improvement. Discovery methods should ensure that staff, processes, data systems, and reporting mechanisms are working as intended to meet minimum standards and/or desired outcomes. CAP/DA draws from several data sources to monitor CAP/DA program performance, including:

1. The AQUIP system (described below);
2. On-site audits and reviews;
3. Desktop audits and reviews
4. The Medicaid Fiscal Agent's MMIS;
5. NC Division of Health Services Regulation for licensure/certification records; and
6. DMA Program Integrity Unit for audits, reviews, and investigations.

Remediation
Remediation is the actions taken to remedy specific problems or concerns that arise. As a first step, identified areas of weak performance are brought up to minimum standards through an understanding of the problem. Subsequently, correction or remedial action should be taken to correct the root causes of the problem to improve performance in the weak area to prevent similar problems in the future.

Continuous Improvement

Finally, the CAP/DA Quality Management Strategy determines how improvements in skill levels, processes, and systems can be established to initiate and sustain higher levels of performance. The changes should, at a minimum, improve system design flaws that allowed for weak performance, but more importantly map out how both existing and improved data and quality information can lead to continuous improvement in the waiver program.

III. Roles and Responsibilities for Oversight and Quality Improvement

The North Carolina Division of Medical Assistance (DMA) is the state Medicaid agency responsible for the administration of the CAP/DA Program. Services are delivered through a network of county agencies called CAP/DA Lead Agencies (lead agencies). There are 96 lead agencies, as described below. In all, five agencies play key roles in the CAP/DA service delivery system, as summarized below.

1. The Medicaid CAP/DA Unit – The CAP/DA unit is one of ten long-term care programs in DMA's Facility and Community Care Section. The primary responsibilities of the CAP/DA Unit include providing overall management oversight of the program, developing and implementing program policies and procedures, conducting the CAP/DA quality management program, setting the county slot allocations, and providing training, consultation, and technical assistance to the lead agencies and CAP/DA providers.

2. The Local CAP/DA Lead Agency – Local CAP/DA lead agencies are selected in each county by the county commissioners and may be a department of social services (DSS), local health department, area agency for the aged, or a hospital. CAP/DA lead agencies perform the following duties:
    a. Process referrals,
    b. Assess applicants for the program,
    c. Provide case management,
    d. Provide home mobility aids and waiver supplies,
    e. Manage caseloads, including DMA's recommendations and putting into writing or policy caseload limits,
    f. Set up and operate an advisory committee,
    g. Develop and approve Plans of Care (POC),
    h. Ensure quality services,
    i. Ensure client freedom of choice, and
    j. Cooperate with monitoring and reporting activities.

3. The Medicaid Fiscal Agent – The Medicaid Fiscal Agent, Electronic Data Systems (EDS), provides the prior approval review for CAP/DA participants, processes and pays provider claims, and provides training related to these activities to provider organizations.

4. CAP/DA Provider Organizations – Provider organizations are enrolled with Medicaid to provide certain defined services, as specified in their enrollment contracts. Provider qualifications are specified in the CAP/DA Clinical Coverage Policy and Provider Handbook.

5. Carolinas Center for Medical Excellence – Carolinas Center for Medical Excellence (CCME) is the federally-designated Quality Improvement Organization for Medicare for North and South Carolina. CCME, under contract to DMA, conducts a comprehensive Internet-based quality management program for the CAP/DA Program called AQUIP. This automated quality management system is described below.

Automated Quality Utilization and Improvement Program (AQUIP) System Description

The Automated Quality Utilization and Improvement Program (AQUIP) is a web-based, automated system used by all 100 counties (which consist of 96 lead agencies) throughout the state to help support the NC Medicaid CAP/DA program. The system helps to identify opportunities for improvement by looking at patterns and trends in individual care. AQUIP is used to:

1. Identify opportunities for CAP/DA systems improvements that will benefit all enrolled participants while assuring the quality of services to each enrollee, and
2. Meet waiver requirements for assurances and quality improvement systems.

The review system captures and assesses data in three areas to assure each individual client receives quality health care that is delivered cost effectively and in the appropriate setting:

1. **Level of Care:** Are enrollees categorized properly, and can this be compared across lead agencies?
2. **Cost:** Are we staying within the cost limits, both at the individual level and at the county and state levels?
3. **Quality:** Are there opportunities for systems improvement? Are there variations between counties that can help us identify ways to more effectively provide services? Are there individuals who need immediate attention?

AQUIP provides an automated assessment and plan of care tool that captures data on all CAP/DA and CAP/CHOICE clients. The client data and resource utilization group scores (RUGs) are analyzed and combined with claims data to help assure all clients receive quality healthcare that is delivered cost effectively, in the appropriate setting. RUGs are used to classify nursing facility residents into groups. Classification is based on a person's physical functioning, disease diagnoses, health conditions, and treatments received.

In addition to providing the automated assessment and plan of care tool, CCME provides the following services:

1. Help Desk Calls (clinical and technical questions)
2. Clinical staff support;
3. Web-based, HIPAA compliant, searchable database that contains data on all CAP/DA and Choice clients;
4. 24/7 secure fax access and data entry support;
5. Automated system that accepts claims data from DMA and matches it to client data and RUG scores;
6. Accepts claims and links them to the client by preparing cost summary reports for use by DMA in monitoring expenditures per client;
7. Assist DMA in implementing a quality measurement and improvement system which can identify both individual and systematic quality issues;
8. Provide training sessions on a quarterly basis for new users;
9. Establish, maintain, and monitor a standardized Waiting List;
10. Development of training videos;

CCME provides a variety of standard reports including:

1. Program applicants by LOC and RUG scores
2. Data Entry Report by County
3. Discharges
4. Inappropriate Services
5. LOC Review Results
6. New CAP/DA Clients
7. QI Maps
8. QI Rank
9. QI Rank All, or by County
10. QI Rank Quarterly
11. RUG Assignments
12. RUG Assignments by County by Category
13. RUG Assignments by County Detail
14. RUG Assignments by County with MID
15. RUG Assignments for CAP CHOICE
16. Summary of County Enrollment
17. Transfers
18. Types of Assessments

IV. CMS Assurances

This Section describes the process and methods the State of North Carolina utilizes to ensure that the HCBS assurances are met in the CAP/DA Program. This section also describes the procedures that will be used to carry out specific oversight of individuals being transitioned from nursing facilities to CAP/DA as part of the MFP Rebalancing Demonstration

Please note that the North Carolina CAP/DA Program is in the process of preparing its first waiver renewal under the Version 3.5 requirements. This renewal is due September 30, 2008.

CAP/DA staff conducted several "town-hall" meetings across the state in May 2008 to obtain input from key stakeholders about the CAP/DA Program, including successes and challenges, and to solicit suggestions for the future direction of the program. CAP/DA staff is currently orienting themselves to Version 3.5 and is in the process of revising the program's Quality Management Strategy to meet the new requirements for state assurances and quality improvement. Again, please note that this document is submitted during the application renewal process and not all planned changes have been implemented. Information provided in boxes is planned changes that have not been implemented.

Level of Care

Sub Assurances 1

An individual evaluation of LOC is provided for all applicants for whom there is a reasonable indication that services may be needed in the future.

North Carolina Medicaid requires that a level of care (LOC) determination be made on all recipients seeking home and community based services, including CAP/DA, by using a standardized prior approval tool (currently the FL-2 form) for determining nursing facility Level of care. The FL-2 is completed by the applicant's physician and initiates the CAP/DA admission process. Procedures are in place to assure that individuals meet nursing facility LOC after a complete assessment has been performed.

Each time a CAP/DA applicant assessment is completed in AQUIP, certain information fields are incorporated into calculating a Resource Utilization Group (RUG) score that is assigned to the applicant. RUG categories were developed by national researchers to classify individuals in nursing facilities into groups that utilize similar types and amounts of staffing resources. Over one hundred (100) data elements are used to determine the RUG classification. Since CAP/DA recipients must qualify for nursing facility level of care, the RUG score determined by AQUIP incorporates the same data elements as the national system. A review of level of care and a recertification of Medicaid-funded services are required for each CAP/DA participant on an annual basis.

When an applicant does **not** meet nursing facility level of care requirements after review of the FL-2 and automated assessment this is noted in the "action required" section of the AQUIP report. Each case manager must then submit supporting evidence to document that the applicant is at risk for institutionalization without CAP/DA services and a plan of action. A CAPDA consultant reviews the documentation, logs in the information, and contacts the case manager to review the case. A final determination is made at this time.

Planned performance measures include:

- Number and percent of LOC determinations made on State-approved form
- Number and percent of LOC determinations that require retro approval

- Number and percent of initial LOC determinations made within ten working days of receipt of request for CAP/DA

Remediation
The AQUIP provides an automated assessment and plan of care tool that captures data on all CAP/DA and CAP/CHOICE clients. The tool reviews 100 percent of level of care determinations. DMA will provide feedback to the lead agencies and, when necessary, establish a corrective action plan to ensure that these requirements are met in all cases.

Sub Assurance 2
The LOC of enrolled participants is reevaluated at least annually or as specified in the approved waiver
Every 12 months, the case manager is required to complete a Continued Need Review (CNR) to determine if the enrolled participant continues to meet CAP/DA LOC requirements. The CNR must be completed during the month of the initial CAP/DA effective date. The lead agency's authorized approval agent must approve and sign the plan by the 5th of the following month. This recertification process requires the case manager to do the following:

1. Obtain a new FL-2 (assessment form) signed by the client's physician with LOC recommendation(no earlier than 30 days prior to the CNR month);
2. Complete a new assessment by RN and social worker; and
3. Complete a new service plan.

AQUIP's LOC review allows categorization of each CAP/DA participant by intensity of services. This data can be compared across lead agencies and other long-term care populations. Portions of the Minimum Data Set (MDS), used in nursing facilities, are included in the AQUIP assessment tool that is completed by lead agency case managers. This information is used to calculate a score for each individual that is compared to the nursing facility level of care.
A performance measure for this assurance is currently in place as part of the AQUIP system.

- Number and percent of participants who received an annual reevaluation within twelve months of initial or previous evaluation (AQUIP-generated report)

Remediation
DMA will provide feedback to the lead agencies and, when necessary, establish a corrective action plan to ensure that these requirements are met in all cases.

Sub Assurance 3
The processes and instruments described in the approved waiver are applied to LOC determination
All LOC determinations are monitored by CCME and CAP/DA and reviewed again by EDS as part of the prior approval process. The CAP/DA Unit is responsible for assuring that this process is conducted in accordance with the approved waiver assurances.

Planned performance measures include:

- Number and percentage of LOC evaluations completed using approved processes and instrument
- Number and percentage of LOC determinations monitored by CCME

Remediation

On-site reviews and AQUIP reports can be use to determine if the LOC process is being completed correctly and if the required tools are used correctly. Remediation will include feedback to the lead agencies, technical assistance, and training.

If, at the time of the CNR, the FL-2 is not called into EDS for approval or the CAP DA Unit questions the validity of the form, the unit will request a new FL2 be obtained and called into EDS.

Service Plans

Sub Assurance 1

Service Plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means

In North Carolina CAP/DA Program, the local lead agency assures that comprehensive information concerning each participant's preferences and personal goals, needs and abilities, health status and other available supports is gathered and used in developing a personalized service plan. Local lead agencies assure that plans of care address all assessed needs and personal goals, either by waiver services or other means. Below is a list of assurances local lead agencies provide to ensure Service Plans address participants needs:

1. Assure that participants are afforded choice among service providers.
2. Participants and/or their legal responsible party actively participate in the plan of care development, and that plans of care are updated or revised when warranted by changes in the waiver participant's needs.
3. Federal Financial Participation (FFP) cannot be claimed for waiver services furnished prior to the development of the plan of care or for services that are not included in the individual written plan of care.
4. All services must be furnished pursuant to the plan of care. If they are not provided per the service plan, the case manager must document who the client's needs are met.
5. The plan of care describes the services and supports (regardless of funding source) to be furnished, their projected frequency, and the type of provider who will furnish each.
6. The plan of care addresses how potential emergency needs of the individual will be met.

For Medicaid audit purposes, a valid plan must:

1. Have the required signatures on or before services begin;
2. Cover the dates of service;
3. Identify the services billed and the amount being billed;
4. Have measurable goals and appropriate interventions;
5. Be updated/revised based on a person's needs, provider changes and/or regulatory changes;
6. Include informal and formal support systems; and
7. Include a 24 hour schedule of coverage if warranted.

A majority of these quality indicators look at plan of care development to assure that CAP/DA is meeting the participants' assessed needs.
Planned performance measures include:

- Number and percent of POCs reviewed that meet all requirements
- Number and percent of POCs that is adequate and appropriate to the waiver participant's needs, as identified in the assessment.

Remediation
CCME reviews cases monthly to determine errors in services that were authorized but not provided, or unauthorized services that were provided. These reviews also determine deficiencies that result from failure to complete the care planning assessment tool accurately. The CAP Case Managers received deviations from the providers and review provision of services monthly. If there are consistent deviations and the service is authorized on the POC, the case manager must review these with the client and discuss a possible change in providers. If the client can be maintained at the deviated service(s), a POC revision must be completed.
Each county lead agency has access to the QI reports and often contacts CCME or the CAP DA Unit for clarification of the score and to verify the accuracy of the assessment question/answer. The case managers can also access the Q and A section of the AQUIP system.

Sub Assurance 2
The state monitors Person Centered Plan development in accordance with its policies and procedures.
In addition to the activities described above for Sub Assurance 1, CAP/DA staff utilizes desktop reviews and on-site reviews (audits), AQUIP reports, and special reviews to assure program accountability for POC development and implementation. Approximately 48 on-site reviews per year are conducted by CAP/DA staff.

The Case Manager establishes the POC in collaboration with the applicant's primary care or attending physician, the applicant, and the applicant's formal/informal caregivers. The case manager is responsible for providing, at a minimum, the following monitoring requirements for waiver services:

1. Adult Day Health, In-Home Aide and Respite Services:
    a. Review the provision of services with the client or responsible party and the provider agency at least monthly;
    b. Observe hands-on service being provided at least every 90-days;
    c. Review supporting documentation for claims at least every 90 days;
    d. Review provider claims prior to filing for payment from Medicaid to monitor for compliance with services in approved Plan of Care.

2. Meals and Personal Emergency Response Systems:
    a. Review the provision of services with the client or responsible party and the provider agency at least monthly; and
    b. Review the provider claims prior to filing for payment from Medicaid to monitor for compliance with approved Plan of Care.

3. Waiver/Medical Supplies - Confirm after initial delivery and at least quarterly if supplies are appropriate for client's needs and use.
4. Home mobility aids - Confirm after delivery/installation and at least quarterly if items are appropriate for client's needs and use.
5. Home Health Nursing visits - Review results of home health agency's nurse visit(s) with nurse once a month if applicable.
6. Home mobility aids - Visit all clients, at a minimum, every 90 days.
7. Case management notes - All activities listed above must be documented in case notes as they occur (dated, time in minutes, appropriately signed, multiple entries totaled).

Planned performance measures include:

- Number and percent of POCs that meet all the requirements specified in the CAP/DA clinical coverage policy
- Percent of waiver participants whose Service Plan included a risk factor assessment
- Number of waiver participants whose Service Plan was based upon a completed uniform needs assessment/instrument (CAP/DA Assessment form)

Remediation

If it is discovered during the monthly monitoring that services are not being delivered in accordance with the Person Centered Plan, the case manager will address the issue with the provider and work to resolve to issue. If the provider fails to adequately address the issue, the case manager may address the issue with the participant and suggest a change of provider. The provider can be reported to DMA's Program Integrity Unit for auditing if warranted, and the lead agency can subsequently revoke the provider's endorsement.

Sub Assurance 3

Person Centered Plans are updated/revised at least annually or when warranted when there are changes in the participants needs

The Case Manager revises the POC as the client's needs change (either improves or deteriorates). The assessment will identify ADL deficits and the linked home management tasks. The status of the CAP/DA enrolled participant is monitored by the case manager, the lead agency authority, and reviewed on an on-going basis by CAP/DA and CCME. POCs are changed when on-going monitoring reveals a change in the participant's needs, situation, or condition to reflect these changes. POCs are also changed as a result of annual reviews.

Planned performance measures include:

- Number and percent of POCs that are updated on or by the person's annual renewal date
- Number and percent of waiver participants whose POC was revised, as needed, to address changing needs.

Remediation

Remediation efforts for this sub assurance are underway. CAP/DA staff will consider a chart audit that will enable DMA to review case notes. The reviewer will look to see if the person's needs changed commensurate with a needed change in the POC and whether or not the POC was actually revised to meet the changing need.

Sub Assurance 4

Services are delivered in accordance with the Person Centered Plan, including the types, scope, amount, duration, and frequency specified in the Person Centered Plan.

The AQUIP system is linked to NC Medicaid's MMIS (claims payment system) and compares paid claims data to the participant's POC. CCME compares the service plan to the paid claims data to ensure that billed services corresponded to the POC.

- Planned performance measures include:
- Percent of participants reviewed who have claims for services not authorized on the POC.
- Establish an indicator that will measure underutilization or whether or not the person received all waiver services in the POC.

Remediation

Provide feedback to lead agencies to make the necessary adjustments in service delivery to correspond with the plan of care. Cases of apparent fraud will be referred to Medicaid Program Integrity.

Sub Assurance 5

Participants are afforded choice between waiver services and institutional care, and between/among waiver services and providers.

All individuals enrolled in CAP/DA sign a POC statement that confirms that he/she was provided a choice between CAP/DA and institutional care. In addition, CAP/DA participants sign a Freedom of Choice form that verifies that they had a choice among waiver services and providers available through NC Medicaid list of providers authorized to provide that service. The Freedom of Choice form is updated annually, or as warranted by client needs.

Planned performance measures:

- Number and percent of wavier participants whose records contained a completed and signed POC that specifies choice was offered between institutional care and waiver services
- Number and percent of waiver participants whose records contain a completed and signed Freedom of Choice form that specifies choice offered among waiver services and providers

Remediation

Remediation will include feedback to the lead agencies, corrective action plan, technical assistance, or training as appropriate.

<u>Qualified Providers</u>

Sub Assurances 1

The state verifies that providers, initially and continually, meet required licensing and/or certification standards prior to their furnishing waiver services

DMA verifies that all Medicaid providers be licensed or certified, as required, and properly enrolled as a Medicaid provider by DMA Provider Enrollment Services for each type of service furnished. Through these rigorous state licensure/certification standards providers must demonstrate competency to perform services. In addition to DMA's requirement for providers to

be enrolled through DMA Provider Enrollment Services, these providers must be authorized by the CAP/DA lead agency for each county where services are provided.
The provider must receive an authorization notice initially, re-issued annually at continued need review and updated as needed. Medicaid recipients have the freedom to choose to receive services from any licensed home care agency that serves their county and they may switch agencies without any restrictions. A provider must document the provision of services before seeking Medicaid payment and this record must provide an audit trail for services billed to Medicaid.

Licensed home care agencies are required to perform the following activities to comply with state laws:

1. Complete background checks on all employees
2. Conduct in-home aide competency evaluations and trainings
3. Monitor quality of care
4. Handle Workers' Compensation
5. Manage the payment of income and Social Security taxes
6. Ensure that in-home aides work under the supervision of a Registered Nurse

Plan performance measures include:

- The number and percent of providers who meet licensure/certification requirements (100% for NC)
- The number and percent of new provider applications for which appropriate background and registry checks, as required by the State, were conducted
- The number and percent of agency providers whose direct support staff had timely criminal background and registry checks (future provider performance survey under consideration)

Remediation
Planning is underway for local lead agencies to provide stronger provider oversight. DMA staff is considering the following actions as the waiver renewal process is underway. If the local lead agency or DMA staff finds the provider out of compliance they may require a corrective action plan. The local lead agencies, through DMA oversight involvement, will then conduct a follow up review to determine if the provider has corrected the issues. If subsequent corrective actions are required, DMA may exercise the right to revoke the provider's endorsement. The Division of Health Service Regulation may also require a corrective action plan, fine the provider or revoke the provider's license for violations discovered.

Sub Assurance 2
The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements
This sub assurance is not applicable to NC Medicaid. North Carolina does not permit non-licensed or non-certified providers to furnish services to Medicaid recipients.

Sub Assurance 3
The state implements its policies and procedures for verifying that provider training has been conducted in accordance with state requirements and the approved waiver

CCME, under its contract with NC DMA, provides quarterly regional training programs throughout the year to newly enrolled providers. In addition, the NC Association for Home and Hospice Care sponsors an annual CAP/DA conference. CAP/DA staff provides ongoing technical assistance and consultations by telephone and on-site when needed.
Planned performance measures include:

- Number and percent of providers, by provider type, meeting provider training requirements
- Number and percent of participating providers represented at training programs calculated annually

Remediation
DMA will ensure that provider training is conducted in accordance with state licensure/certification requirements, DMA clinical policy, and waiver requirements. DMA accepts DHSR's licensure of home care agencies and if any continuing education is required, DHSR conducts supplemental training. CAP/DA staff review CCME's training course materials and verifies that provider training programs meet the state administrative requirements, program policy, and waiver requirements.

Health and Welfare

Sub Assurance:
The state, on an ongoing basis, identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation
Participant health risk and safety considerations are assessed and potential interventions identified that promote health, independence and safety with the informed involvement of the participant. Local lead agencies assure that services and supports are included in the POC to address risk and safety issues identified in the assessment. Case managers monitor specific triggers in the assessment in the assessment that should have corresponding POC inclusions, including medication confirmation, fall risk, need for assistive devices, and need for Personal Emergency Response System (PERS).

The NC Division of Health Services Regulation (HSR), the State's provider licensing agency, houses a Complaint Intake Unit which investigates complaints regarding the care and services provided to patients/residents/consumers by health care facilities, provider agencies, and group homes. Complaints may be shared with the Unit by telephone, by facsimile or by postal mail. The Unit is able to investigate complaints regarding incidents that have occurred in the past year and issues that are regulated by federal regulations or state statutes (see below for a list of common non-regulatory issues). A Complaint Form is available for written complaints but is not required to be used. Each complaint is prioritized for investigation according the seriousness of the situation. Complaints are investigated by the appropriate licensing Section within the Division. Investigations are unannounced to the facilities/agencies/homes, and complainant identifying information is not shared with the facilities/agencies/homes. Complaints received by our Complaint Intake Unit for Adult Care Homes are forwarded to the local Department of Social Services for investigation.

In addition, DMA has mandatory reporting requirements for all providers. North Carolina statutes require any person having reasonable cause to believe that a disabled adult is in need of protective services shall report (either orally or in writing) such information to the director of the county Department of Social Services. County Departments of Social Services must accept all reports alleging an abused, neglected or exploited disabled adult is in need of protective services. County Departments of Social Services report to the State department of Social Services.
In addition to reports of abuse, neglect or exploitation, there are also systematic safeguards in place to protect participants from critical incidents and other life-endangering situation. DMA requires that critical events or incidents be reported for review and follow-up action. Critical events include decline in mental or physical health and/ or loss of informal support that affect the ability of the participant to self direct. If this occurs, care advisors reassess the participant's situation to determine whether the participant-directed option continues to be appropriate for the individual. Personal assistants and other direct workers who are in touch with the participant on a regular basis are instructed to report problems to the care advisor. After hours, North Carolina's *CareLine,* a toll-free hotline designed to assist North Carolina citizens in need of supports and services, has live operators 24 hours a day, seven days a week. See section V. (24 hour back up) for more information describing NC's 24-hour *CARELINE*.

Planned performance measures include:

- Number and percent of medication errors (AQUIP, I, 6)
- Fall risk score (AQUIP, H, 4)
- Need for assistive devices (N, 3)
- Need for PERS (AQUIP, H, 1 and 4)
- Number and percent of cases appropriately reported and investigated where notes in case files indicate abuse, neglect, or exploitation.
- Number and percent of reportable critical incidents, by type
- Number and percent of reportable critical incidents being investigated, by type
- Number and percent of critical incidents for which corrective actions were verified within required time frame.

Remediation
The case manager must ensure that the POC is kept current with the participant's changing needs. When the case manager discovers that a participant is at risk s/he must address the issue immediately or in a timely fashion as required. This may include anything from calling a team meeting to address the issue to getting medical advice for the participant to seeing that the participant is removed immediately from the environment that has him or her at risk. If the case manager discovers that the participant has had multiple incident reports submitted for the same or different incidents, s/he must address this with the team or in whatever manner is necessitated by the severity of the incident. The case manager must ensure that the POC is updated on a continuous basis as the participant's needs change.

As part of the CAP/DA waiver renewal, DMA will set more rigorous requirements to ensure local lead agencies and providers report all complaints, specified types of incidents, and any observed or suspected participant abuse, neglect or exploitation.

Administrative Authority

Sub Assurance:
The Medicaid agency retains ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of the waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.
DMA is responsible for all Medicaid programs including CAP/DA and as the state operating agency maintains authority and oversight responsibilities for all entities participating in this program and entities providing services to program participants. Specifically, CAP/DA staff conducts on-site compliance reviews annually to ensure local lead agencies follow waiver policies and procedures are implemented. DMA also oversees CCME who performs ongoing quality assurance and utilization management functions. CAP/DA unit has "real time" access to assessments, plans of care and quality indicators.

Any policy and/or regulation changes which impact waiver operations must follow the agency's approval process. Final decision-making rests with the DMA and recommendations made by a Physicians Advisory Group (PAG). This process ensures Division of Medical Assistance authority.

Planned performance measures include:

- Number and percent of lead agencies audited that have a passing score for compliance with waiver requirements

Remediation
CAP DA staff in DMA must review all waiver policies, rules, procedures, rates and service definitions prior to their final approval. If DMA has an issue with any item reviewed, they will notify the appropriate stakeholders (e.g. local lead agencies, providers, etc.) to correct the issue. In addition, if a lead agency is found to be out of compliance they can be terminated or local approval can be removed for a period of time during remediation, training, or technical assistance provided by CAP/DA staff.

In conjunction with CAP/DA's waiver renewal (9/30/08), planning is underway to write administrative rules for CAP/DA to give the state greater authority to set statewide standards, criteria, and administrative requirements. The clinical coverage policy will also be revised to strengthen greater state control over local lead agencies.

Financial Oversight

Sub Assurance:
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.
The Medicaid Fiscal Agent – EDS - is responsible for ensuring that CAP/DA claims are paid correctly. All services are appropriately coded and audits and edits within the system ensure that claims are paid correctly.

CCME monitors paid claims to ensure that they are coded and paid correctly and that they correspond to the approved services in each participant's POC. The Medicaid CAP/DA Unit monitors expenditures to ensure that monthly benefit limits are not exceeded and the program stays within its approved budget.
Planned performance measures include:

- Number and percent of claims reviewed that are coded and paid correctly (financial audit)
- Number and percent of claims adhering to reimbursement methodology in the waiver application
- Number and percent of claims reviewed where the claims paid are only for services specified in the participant's POC.
- Number and percent of participants reviewed that are within their monthly benefit limit

Remediation
In conjunction with CAP/DA's waiver renewal (9/30/08), planning is underway to change payment methodology from monthly limits to aggregate funding. CAP/DA staff will work with the DMA Budget Office and CCME to develop methodology to track aggregate funding against the approved CAP/DA budget.

V. Critical Incident Reporting

The State, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation. Case managers will be required to report monthly on substantiations of abuse and neglect for Money Follows the Person participants.

Additional critical incidents for the aged and disabled population include falls, unplanned weight loss and unplanned hospitalizations. These are reported during the initial assessment, at annual continued need review and as needed in change of status assessment. Data is collected and accessed through AQUIP. Reports are run quarterly are reviewed to ensure that appropriate action was taken at the time of the incident. Reports are provided to the lead agencies and Division of Medical Assistance staff.

VI. Risk Management

Diagnoses and symptoms that pose a significant risk to health, safety, and well-being of each CAP/DA and CAP/CHOICE participant is identified as part of the intake and assessment process. These items are entered into the AQUIP assessment tool along with the Service Plan which is completed using the AQUIP Plan of Care Tool. The AQUIP system has the capacity to compare identified risk factors with elements of the plan to ensure these risks are adequately addressed for all CAP/DA and CAP/CHOICE participants. Each risk identified by the assessment process must be addressed in the individual's service plan.
Some example scenarios where service plans should address risk factors identified in the assessment process include:

1. An individual identified with a fall risk may need to have assistance while ambulating through the use of gait belt;

2. An individual with diabetes requires continuous monitoring of blood glucose levels (AC1s), specialized diet and physical activity;
3. An individual with a history of decubitus ulcers requires regular and continuing monitoring of skin to detect and prevent skin breakdowns; and
4. An individual with hypertension will require regular and continuing monitors of blood pressure.

Additionally, case managers monitor service plans with special consideration given to diagnoses and symptoms where risk is more inherent and evaluate if these risks are addressed adequately on at least a monthly basis. Assessments are completed at intake, during continued need reviews, or as needed, when the health of the participant changes. Every time the assessment (initial, CNR, or a change in status) is completed, a plan of care is completed or amended based upon the most current assessment.

AQUIP generates reports of service plans that do not address risk factors identified in the assessment. These reports are reviewed by CAP/DA staff and feedback is provided to the specific CAP/DA lead agency where the assessment and service plan were completed. The interventions, as set forth in the individual's service plan, designed to minimize risk will be assessed during site reviews to assure they are functioning and are being implemented as designed and intended.

VII. CAP/DA and CAP/CHOICE – 24-Hour Back Up

While the need for 24/7 care coverage is assessed and addressed in each CAP/DA participant's service plan, including a back up plan for needed care coverage that includes formal and informal supports, there are times when the most comprehensive service plans can be insufficient.* For participants with diagnoses that require rapid access to EMS CAP/DA provides for the use of telephone response systems. The CAP/DA case manager checks this system on a monthly basis to ensure it works properly and reviews any reports from the Emergency Response System Provider. This case management activity is documented in the client's case notes.

For other non-emergency but critical support needs, the CAP/DA Case Manager is available to assist the participant during the agency's normal business hours. Information regarding these interactions is available to Division of Medical Assistance staff during participant record reviews during lead agency site audits. In addition, the case manager is required to perform a monthly review of the provision of services with both the client and the agency providing the services. Any deviation in waiver service provision is to be documented in case manager's notes and a detailed description of how the client's needs were met are included. Division of Medical Assistance staff provides feedback regarding any deficiencies noted during the review including inadequate actions and issues not handled in a timely manner.
After hours, North Carolina's *CareLine*, a toll-free hotline designed to assist North Carolina citizens in need of supports and services, has live operators 24 hours a day, seven days a week. The *CareLine* operator is able to assess a participant who is in a crisis or emergency and can coordinate access to critical medical supports. *CareLine* staff logs and tracks each call and compiles reports and recommendations for each encounter. The Division of Medical Assistance

recognizes the importance of evaluating this data and will work collaboratively with the *CareLine* program to develop regular reporting and a method for evaluating and using this information to improve the quality of CAP/DA. MFP clients will be flagged in the system and report will be generated specifically on these clients.

* 24 Hour Care Coverage Plans are completed for only those participants identified as needing around the clock care supports critical for his/her health and welfare. For the purposes of the Money Follows the Person Project all participants designated for MFP are required to have a 24 hour coverage plan, regardless of the need for 24 hour care coverage.

VIII. Evaluation of Quality Management

The Facility and Community Care (FCC) Section of the North Carolina Division of Medical Assistance (DMA) is responsible for managing ten Medicaid long-term care programs and services, including three home and community-based (HCBS) 1915c waiver programs – CAP/DA, CAP/CHOICE, and CAP/Children. These HCBS waiver and Medicaid state plan services are provided in facility, assisted living, and home and community-based settings. FCC staff has been developing a section-wide Quality Management Program to improve the overall quality of long-term care services provided to Medicaid recipients. The overarching purpose of the Quality Management Program is to develop, implement and continuously improve a quality management system that incorporates the strategies and related activities documented in the Quality Management Work Plan. The HCBS Quality Framework and HCBS waiver assurances work together as the blueprint for the FCC Quality Management Plan.

For the HCBS waiver programs, including CAP/DA and CAP/CHOICE, FCC will employ a Quality Improvement Strategy Plan based on the assurances in Version 3.5 HCBS Waiver Application. This document begins a dialogue of how FCC is conducting an evaluation of quality management systems for its HCBS waiver programs and state plan services.

Attachment H1

North Carolina
DMH/DD/SAS
Quality Management Strategy for Money Follows the Person (MFP)
For Persons with Mental Retardation/Developmental Disabilities
June 14, 2008

Introduction and Purpose

The purpose of the Quality Management plan is to ensure that discovery processes and systems for remediation and quality improvement take into consideration the specific and unique needs of individuals with developmental disabilities leaving public institutions and private ICFs. Components of the plan include oversight and evaluation of the transition process, the successes and barriers to success in community living, the effectiveness of back-up systems, and the risks that might lead to harm and/or re-institutionalization.

North Carolina is aware that this MFP initiative occurs within the state's overarching Quality Management System for HCB waiver services. To the degree possible it will enable the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) to collect data across all CAP-MR/DD waiver participants and compare data between Money Follows the Person (MFP) and non-MFP waiver participants.

The North Carolina Quality Management System (QMS) is designed to capture data and address issues at every level---individual, provider, local management entity (LME), and state. Section I includes a description of each level's roles and responsibilities to ensure quality. Section II describes the various discovery processes/data sources that are employed to measure quality across all the CMS assurances generally and the quality of services and supports to MFP participants specifically. Section III aligns the discovery processes and responsibilities with all the CMS assurances. Section IV describes how data from the various monitoring processes are used to develop improvement strategies. Section V describes how the QMS is evaluated to ensure that it continues to generate valid, reliable and actionable data.

I. Roles and Responsibilities for Oversight and Quality Improvement

Each level of the system has well-defined roles and responsibilities to ensure the quality of the services and supports. While this is important for all individuals with developmental disabilities receiving CAP-MR/DD waiver services, it is even more critical for individuals transitioning from institutions who, in all likelihood have intensive support needs. Following is a description of specific roles and responsibilities beginning with monitoring at the most important level--- the individual.

- **Individual Level**
    - **Transition coordinators** identify needed and preferred services with the individual and family. Transition coordinators ensure that the transition plan addresses any risks that might be a barrier to a successful transition to community life.

- **Case managers** are responsible for facilitating the development of the Person-Centered Plan/Plan of Care (PCP/POC) and ensuring that it includes all needed services and supports. The case manager ensures that the PCP/POC includes an updated risk assessment and any services/supports necessary to mitigate risk over time. As well, the case manager has a key role in the development of a viable back-up plan. The case manager has primary oversight responsibility for monitoring the implementation of the PCP/POC to determine whether identified services and supports are being delivered and if the individuals' needs change, that the plan is revised. Case managers conduct monthly visits to oversee PCP/POC implementation, ensure health and safety, identify any additional risk factors and determine whether the back-up plan remains effective. Monitoring will be governed through use of a standardized monitoring tool.

- **Provider Level** quality management responsibilities are as follows:
  - Implement the PCP/POC, including risk mitigation strategies and the back-up plan.
  - Address Level I incidents (e.g., injuries that do not require hospitalization or medical treatment other than first aid).
  - Report quarterly aggregate information to the LME on a Level I incidents.
  - Report Level II incidents to the LME (e.g., incidents where police are involved, injuries requiring medical treatment).
  - Report Level III incidents to the LME and DMH/DD/SAS (e.g., incidents that cause permanent injury or death).
  - Develop and implement an internal quality improvement plan.
  - Develop and convene an internal client rights committee.

- **Local Management Entity (LME)** quality management responsibilities are as follows:
  - Serve as the single portal for HCB services eligibility.
  - Provide or arrange for 24/7/365 crisis response system.
  - Conduct the endorsement process for providers.
  - Conduct ongoing monitoring of endorsed providers based on a standardized monitoring protocol and scheduled based on a confidence level calculation.
  - Provide technical assistance to providers.
  - Oversee and provide follow-up of to ensure implementation of plans of correction.
  - Implement a quality improvement system that includes an incident review committee, external consumer/family advisory committee (CFAC), quality improvement committee, and client rights committee.
  - Receive, track and respond to participant complaints and appeals.
  - Receive, track and respond to incident reports from providers; prepare incident trend reports for DMH/DD/SAS.
  - Assess community service needs and develop provider capacity.
  - Monitor and oversee the transition process for individuals returning to the catchment area from a state institution.
  - Monitor and oversee case managers working with individuals leaving state facilities to ensure they are monitoring health and safety and implementation of the PCP.

- **State Operating Agency – Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS)**
    - Assist in the identification of individuals choosing the option to return to community living though implementation of a standardized Community Options Interest Survey
    - Collect, aggregate and analyze statewide and sub-state incident and complaint data
    - Develop expectations through the promulgation of performance contracts with LMEs
    - Routinely monitor the performance of LMEs
    - Conduct yearly accountability audits of the LMEs and providers, including a targeted review of all participants in MFP, using a standardized review instrument
    - Conduct surveys of individual and family outcomes
    - Conduct reviews of high cost PCPs (over $85,000) and all PCPs of individuals participating in MFP regardless of cost, using a standardized survey instrument

- **Single State Agency - Division of Medical Assistance (DMA)**
    - Conduct monthly audits of a sample of LOC/PCPs for waiver participants.
    - Conduct fiscal audits of the waiver programs.
    - Review data/evidence from DMH/DD/SAS on the waiver program.
    - Require remediation by DMH/DD/SAS for any identified issues and conduct ad hoc reviews of the waiver program.
    - Meet with DMH/DD/SAS on at least a quarterly basis to review trends and to communicate information on any new CMS policies and procedures.
    - Enroll qualified providers.
    - Oversee the performance of the Utilization Review vendor (UR vendor).

II. Money follows the Person Discovery Processes/Data Sources

- **Pre-Transition**

Individuals (and their families/guardians), who currently reside in State Developmental Centers or community ICF MR living arrangements, will at least on an annual basis:

- Complete a Community Interest Survey with their family and or guardians.
- Be given the information on what an HCB waiver is; what the advantages of participating in the HCB waiver are; and be given the opportunity to learn more about the HCB waiver at their annual review meeting.
- Be allowed to express an interest in participating in the HCB waiver program. If a request for participation is made, the DD Center staff will be responsible for assisting the individual and their team in the next steps for community living.

- **Case Management Monitoring Protocol**

  In the service array for participants in the MFP project, case management plays a crucial role. The case manager's most important task is to meet with the participant at least monthly to monitor and determine if all services in the PCP/POC are being provided according to the plan, if the back-up is being implemented as written, if the participant is satisfied with services and if the participant's service/support needs or preferences have changed. There

are other tasks conducted during the face to face meeting, but the most important is the evaluation of the participant's health, safety and welfare and the timely and appropriate action taken if a risk to the health, safety or welfare is discovered. A Case Management monitoring tool is being developed specifically for use by the case manager to assess the MFP participant and the delivery of the services and supports identified on the PCP/POC, during the face to face meeting. The monitoring tool will address health changes, back-up plan, risk factors such as injuries, incidents, needs changes, etc.

- **Backup Plan**

  The CAP-MR/DD waiver guidelines require all providers to have a process for ensuring 24 hour back-up (24/7/365) availability, so that a live person is accessible when needed. All participants of CAP-MR/DD waiver services are informed of and provided with information related to back-up staff at the time of identification of provider and during the PCP/POC planning process.

  Providers of 24 hour services and Targeted Case Management services act as the First Responders if and when the participant or a member of their support system initiates contact for assistance in the case of an emergency. The provider is required to notify the participant and his or her support system of the process for accessing emergency services 24 hours a day, 7 days a week, 365 days a year, both orally and in writing at the initial contact. The notification includes contact information for an alternate source of assistance in the eventuality that the provider is not available.

  The PCP/POC is expected to address how the provider will ensure back-up staff are available, if the staff regularly assigned to provide services are unavailable. The back-up staff must be trained to meet the specific needs of the participant, as detailed in the PCP/POC, including health, mobility, communication, risks behavioral issues, and skill training.

  Each provider will be required to document and track receipt of calls and requests for back-up staff and staff unavailability. This report will be submitted to the LME on a monthly basis for tracking and analysis.

- **Utilization Review (UR) Process**

  The CAP-MR/DD case manager annually reassesses the participant's need for CAP-MR/DD funding by completing a Continued Need Review (CNR). The case manager completes a CNR to determine if the person continues to meet criteria for ICF-MR LOC and remains appropriate for CAPMR/DD funding. The CNR is completed during the birth month of the individual. The NC-SNAP must also be updated during this time. If the CNR is not completed and submitted within the local approval timelines, the person must be terminated from CAP-MR/DD services. Claims for services provided after the CNR month will be denied and may not be recouped.

  The Case Manager (CM) is responsible for submission of all CNR(s) to the state-contracted UR vendor in a timely manner to ensure continued service. The LME is responsible for monitoring CM agencies to ensure compliance to CAP-MR/DD waiver requirements.

  1. Each CM agency will provide the LME a monthly *Caseload Report* listing all CNRs due that month. The report includes the participant's name, address, provider(s), date of birth, date of last CNR, MR 2 reviewed by the LME, and CM agency name and point

person. The LME will be responsible for forwarding the *Caseload Report*, per CM agency, to the UR vendor monthly. The UR vendor will develop and implement a database to track the CNR(s) received or missing. This information will be updated at least annually or as necessary.

2. The CM will develop a tickler system indicating PCP/POC due dates for each participant on their case load to serve as a management tool to ensure the completion of PCP/POC(s) in a timely manner.
3. The LME review will note the date of receipt of the MR2 on the noted list.
4. The CM will submit the PCP/POC information to the UR vendor prior to the birth month for review.
5. The UR vendor will report to the LME (using the information from their tracking database) by the first day of each month the names of participants and the assigned CM agency for which they have not received a completed PCP/POC.
6. The LME will be responsible for contacting the CM agency by the 5th business day of the month to determine the reason for the lapse of the PCP/POC and take the necessary corrective action.
7. The CM agency will submit to the LME and UR vendor a completed PCP/POC within 5 days of the notice from the LME of the lapsed PCP/POC.
8. The LME will supply to the DMH/DD/SAS Best Practice Team a ***PCP/POC Timely Submission Report***, by the 15th of the month, indicating the names of the CM agencies that have submitted PCP/POC(s) beyond required timelines, Including the specific Case Manager(s) and the corrective action implemented.
9. The DMH/DD/SAS Best Practice Team will follow-up with LME(s) regarding the ***PCP/POC Timely Submission Report*** to ensure appropriate corrective actions are implemented and systems are in place to ensure timely submission of PCP/POC(s).

The DMH/DD/SAS Best Practice Team will conduct a clinical and technical review of the PCP/POC of participants of MFP to determine whether they comport with the waiver policy and procedure, state's policies and procedures including any required assessments, timelines, crisis plans, risk assessments, etc. This review includes assuring that issues identified in risk assessment, assessments, and evaluations have been addressed; that identified needs of the individual are addressed and appropriate providers have been identified. The Best Practice Team also reviews the plan to assure consumer rights has been protected through the individual's involvement in the planning process, consent for services and external reviews such as Human Rights Committees as appropriate. The review includes assuring that items identified in the risk assessment are addressed and protections of rights have been included. PCP/POCs not meeting guidelines will be reviewed with the UR vendor and/or the CM and corrections will be made to bring the plan in compliance prior to the approval of the plan.

The Behavioral Health Unit of DMA and the UR vendor conduct quality assurance reviews monthly that include a review of the PCP/POC for individual waiver participants. Each month DMA selects a random sample of 15 PCPs/POCs that were active on the last day of the review month. The state contracted Utilization Review vendor conducts a monthly audit of 25 randomly selected PCP/POCs to supplement the DMA audit.

Reviews occur either on site or the records are sent by the provider to DMA and the UR vendor for a desk review. The reviewer looks for a current MR2, documentation that the participant is at risk of institutionalization or was de-institutionalized, where the participant resides while on the program, and a current, approved PCP/POC to insure that services are appropriate to the needs of the participant. The PCP/POC is further reviewed to insure that services and supports provide for the participant's health, safety and well being and that services were provided according to the approved PCP/POC during the review month.

- **LME Endorsement of Qualified Providers**

  The LME(s) are required to complete the Provider Endorsement process per request by providers seeking to become directly enrolled Medicaid providers. Provider Endorsement is a verification and quality assurance process using statewide criteria and procedures. Provider Endorsement is a prerequisite for direct enrollment with the DMA and consists of two parts: business verification and site/service approval. An endorsed provider must be directly enrolled by DMA prior to delivering and billing covered Medicaid services.

  In order to ensure providers continue to meet established quality standards LME(s) conduct re-endorsement of providers three years after the initial endorsement. This process includes verification of the National Accreditation status of the provider and a letter of attestation, using return receipt/certified mail, that includes the current business information (name, business status, and address), and any dissolutions, revocations, or revenue suspensions that have occurred over the past 3 years. The LME retains the right to conduct an onsite review based on the information contained in the letter of attestation. If the information submitted meets endorsement requirements the LME renews the Provider endorsement for three more years. If at any time the provider organization's National Accreditation status lapses or is withdrawn, the provider organization must notify the LME**.**

- **LME Monitoring of Providers**

  The LME(s) have responsibility through the Performance Contract with the DHHS (See next section) for Provider Monitoring. Such monitoring does not duplicate regulatory authority or functions of agencies of the DHHS. It includes first responder capacity and quality, consumer rights protection, and compliance with documentation requirements. In addition, a function of the LME is to assure to the DHHS that providers in the LME catchment area are in substantial compliance with requirements of the service for which the LME has endorsed the provider. The LME must evaluate its level of confidence in at least one fourth of the endorsed and/or contracted providers in its catchment area each quarter, and monitor 100% of providers rated in the lowest category of confidence every quarter.

  LME monitoring of providers includes determining providers' progress in achieving national accreditation, first responder capacity and quality, compliance with data submission requirements, consumer rights protection, incident reporting requirements, meeting defined quality criteria, adherence to evidence-based practices in the delivery of services and compliance with DHHS documentation requirements. (Although there is currently not a specific measure in place related to 24-hour back-up requests, it is clearly a function of the LME monitoring processes and will be incorporated into the Performance Contract within two years of the waiver implementation.) The Frequency and Extent Monitoring (FEM) tool to determine confidence levels and standardized monitoring tools are being implemented statewide to ensure that providers remain in compliance with the aforementioned criteria.

- **DHHS Monitoring of LMEs**

  The DHHS has a contractual relationship with the LMEs. Annually the DHHS and each LME sign a LME Performance Contract indicating the specific roles and functions of the LME, including specific performance indicators. The DMH/DD/SAS has a variety of methods for monitoring the LMEs' performance regarding the DHHS LME contract. The DMH/DD/SAS LME Systems Performance Team (LME Team) has direct responsibility for monitoring the performance of the LMEs based on the DHHS LME Performance Contract. The DMH/DD/SAS monitors the LMEs for compliance with the terms of this Contract and publishes individual and comparative reports regarding the LME's performance under this contract. The LME Team works with the LMEs providing technical assistance regarding the findings of the reports.

  DMH is developing a comprehensive systematic monitoring process to address the nine functions indicated in the DHHS LME Performance Contract.

- **DHHS Monitoring of Providers**

  Annually the Accountability Team and the DMA Behavioral Health Unit conduct a Medicaid Compliance Audit that includes CAP-MR/DD waiver services. Auditors review directly enrolled Medicaid providers using a two stage simple random sample. The first stage of the sample is of directly-enrolled providers of CAP-MR/DD services distributed across the state. The second stage is a sample within each provider agency of claims paid for services provided during a specific time period. This review includes monitoring of requirements that address staff qualifications, service authorizations, PCP/POC, service documentation, and billing protocol.

- **Complaint Review**

  The DMH/DD/SAS Accountability Team and the DMA Behavioral Health Unit conduct on site reviews of all LME and provider responses to reported complaints. The DHHS Performance Contract with the LMEs requires that the LME report quarterly on complaints and use complaint data for planning, decision making, and improvement. The reports analyze and summarize patterns and trends related to consumers, including incidents and client rights issues, as well as complaints. Maintenance of a fully functioning Client Rights Committee is a requirement of the LME in the Performance Contract between DHHS and the LMEs. This is monitored through the DMH/DD/SAS Customer Services Community Rights (CSCR) Team' analysis of data on complaints that come to the state, as well as annual Client Rights Committee reports that are submitted by the LMEs to its Area Board.

- **National Core Indicators**

  DMH/DD/SAS will collect information on individuals involved in the MFP program and their families through the National Core Indicators (NCI) surveys, a joint project between the National Association of State Directors of Developmental Disabilities Services (NASDDD) and the Human Services Research Institute (HSRI). Face-to-face interviews will be conducted on a random sample of about 1,200 individuals with developmental disabilities who received services other than case management in the survey year. In addition, surveys will be mailed to the family members or legal guardians of the individuals in the random sample eligible for the mailed survey. The surveys provide data on a variety of domains that include individual outcomes and satisfaction with the services and supports that the

individual receives from developmental disabilities services. DMH/DD/SAS will review the survey questions and if needed, add specific questions relevant to the MFP program.

- **Risk Management/Mitigation**

  As a preliminary step, the MR2 assessment form which documents ICF-MR level of care, along with the NC-Service Needs Assessment Profile (NC-SNAP), will be used to identify potential risks to the participant. A Crisis Prevention Plan is incorporated within the PCP/POC. The Crisis Prevention Plan includes supports/interventions aimed at preventing a crisis (proactive) and supports and interventions to employ if there is a crisis (reactive). The proactive plan aims to prevent crises from occurring by identifying health and safety risks and strategies to address them. The reactive plan aims to avoid diminished quality of life when crises occur by having a plan in place to respond. The planning team are to consider what the crisis may look like should it occur, to whom it will be considered a "crisis", and how to stay calm and to lend that strength to others in handling the situation capably.

  Other assessment tools will be utilized to identify potential risks for all MFP participants. The Risk Assessment tool identifies potential risk, such as but not limited to, situational, environmental, behavioral, medical, and financial risks. If a risk is identified and the planning team concurs, the risk identified will be documented within the Crisis Prevention Plan of the Person Centered Plan. The Supports Intensity Scale (SIS) is an assessment tool that measures practical support requirements of a person with an intellectual disability. Unlike traditional assessments, the SIS focuses on what daily supports a participant needs to live as independently as possible within their community. A major strength of the SIS is that it identifies supports that are needed to help a participant be successful in a variety of life domains. As such, during the PCP/POC planning meeting, as needs are identified, corresponding supports should also be identified to assist the consumer in meeting those needs. The PCP/POC will identify and document strategies to address risks identified in the Risk Assessment Tool and the SIS. The Risk Assessment Tool and the SIS can be used independently or in collaboration to identify potential risk to the participant.

- **Incident Management System**

  North Carolina Administrative Code 10A NCAC 12G.0603 requires all LMEs and agencies providing mental health, developmental disabilities or substance abuse services to any person receiving public funds to participate in the DMH/DD/SAS-coordinated system for responding to and reporting critical incidents and other life endangering situations. This will include the MFP participants. Critical Incidents are defined as any happening which is not consistent with routine operation of a facility or service in the routine care of participant and that is likely to lead to adverse effects upon the consumer. This system addresses deaths, injuries, behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and participant behavior issues.

  Providers are responsible for responding to all incidents and submitting to the LME reports on all Level II incidents (e.g., incidents where police are involved, injuries requiring medical treatment). Providers submit to both the LME and to DMH/DD/SAS reports on all Level III incidents (e.g., incidents that cause permanent injury or death). Providers also report quarterly aggregate information to the LME on a Level I incidents (e.g., injuries that do not require hospitalization or medical treatment other than first aid).

LMEs are responsible for ensuring that providers submit incident reports as required and respond appropriately to minimize harm from the incident and the likelihood of future incidents.

LME's must report to DMH/DD/SAS quarterly on their analysis and response to trends on all incidents and deaths as part of the Performance Contract with the DHHS. The DMH/DD/SAS Quality Management and CSCR Teams provide oversight and technical assistance to the LMEs to ensure that Level III incidents are fully addressed by providers.

The DMH/DD/SAS Quality Management (QM) Team maintains an internal database on reported Level III incidents. From this data and the Quarterly Incident Reports submitted by the LMEs, quarterly and annual trend analysis reports are created and reviewed by the team for comparison on an LME level. The QM Team reviews the reports to identify trends that may need to be responded to by remediation and improvement activities to assure that the underlying philosophy and assurances of the CAP-MR/DD waiver are maintained. The Internal QM Review Committee (See Section IV) will also review these reports to identify trends and issues that may need remediation and improvement activities

III. CMS Assurances

The following describes the ways in which the State of North Carolina ensures that the HCBS assurances are met. This section also describes the additional ways in which the state will carry out specific oversight of individuals leaving public institutions within each assurance.

- **Level of Care**

  An individual evaluation of LOC is provided for all applicants for whom there is a reasonable indication that services may be needed in the future.

  Currently the LME prioritizes applicants using a standardized Prioritization process. The MFP participants will be considered top priority for CAP-MR/DD waiver funding. CAP-MR/DD slots will be available for the MFP participants. All applicants, including MFP applicants, must have an approved LOC evaluation to determine if the applicant meets ICF-MR/DD level of care criteria before CAP-MR/DD waiver services may be implemented. The case manager submits the required LOC documents (MR-2 and a diagnostic assessment by a psychologist) to Murdoch Center (a DMH/DD/SAS Developmental Disability Center). The Murdoch Center LOC staff reviews the documents using the processes and instruments described in the approved CAP-MR/DD waiver to make a LOC determination. If the documents indicate the applicant meets the criteria for CAP-MR/DD waiver services, the LOC is approved.
  The approved initial LOC documents are compared to the names of the prioritized applicants to make sure all prioritized applicants receive an LOC evaluation. The LOC reviewer maintains a database of reviewed, denied and approved applicants, their case managers and LMEs. A monthly report is generated as well as an annual aggregate report.

Remediation

If it is discovered that an applicant for whom a slot has been identified has had no initial LOC application, the LME contacts the case manager to have the initial LOC evaluation started.

If the review process indicates the initial LOC evaluations are incomplete or need additional information, the Murdoch reviewer returns the documents to the LME who returns the documents to the case manager along with a request to amend the documents so that the review may be completed. The case manager has fifteen (15) days to return the amended documents to the reviewer. The reviewer has five (5) days to complete the review process. Murdoch maintains a database of these LOC evaluations, issues encountered and timeliness of submission and resubmission. The database also reflects the case managers and LMEs who serve the applicant. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH/DD/SAS QM Team. A CAP-MR/DD Waiver Database is being developed to maintain the data from all waiver-related reviews. This database will facilitate the aggregation and analysis of the data.

The LOC of enrolled participants is reevaluated at least annually or as specified in the approved waiver.

The PCP/POC must be updated annually for all enrolled CAP-MR-DD waiver participants, including the MFP participants. The annually updated PCP/POC is referred to as the Continued Need Review (CNR). The case manager submits the CNR to the UR vendor who is responsible for its review and approval. The UR vendor compares the list of participants who require a Continued Need Review (CNR) each month and the participants who have had the CNR completed by their birthday month. Using the same process as the UR vendor, the DMH/DD/SAS reviews all PCP/POCs for the MFP participants and all plans over $85,000. The UR vendor and DMH/DD/SAS have ten (10) days to complete the reviews. Data will be generated by the UR vendor with DMA on the CNRs due each month, CNRs approved/denied, and CNRs not submitted according to the waiver timeline, grouped by case manager and LME. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH QM Team.

Remediation

If the UR vendor or DMH/DD/SAS reviewers find issues with the CNR, they contact the case manager and request that corrective action be taken. The case manager has five (5) days to re-submit the CNR. DMA and the UR vendor conduct approximately 40 quality assurance reviews of PCPs/POCs each month. This review involves the evaluation of the participant's need for waiver services.

If issues are identified, the reviewer alerts DMH/DD/SAS, which contacts the case manager to request corrections. Both agencies maintain a database of the results of these PCP/POC evaluations, including issues encountered and timeliness of submission and resubmission. The databases also reflect the case managers and LMEs who serve the applicant. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH/DD/SAS QM Team.

If it is discovered that a participant does not meet LOC definitions, the DMA notifies the DMH/DD/SAS, which contacts the LME who contacts the case manager to re-submit an updated LOC packet, so that eligibility may be re-evaluated. If it is ascertained that the participant does not meet eligibility requirements, his/her services will be suspended and non-waiver services will be pursued by the case manager. The case manager informs the participant of their appeal rights included in the DHHS appeals process.

If it is discovered that a participant does not meet LOC definitions, the DMA will also provide technical assistance to the LOC reviewer to prevent other non-eligible persons from being approved for waiver services in the future.

The processes and instruments described in the approved waiver are applied to LOC determination

The DMA, the UR vendor, and DMH/DD/SAS conduct a monthly review of PCP/POCs that includes a review of the participant's need for waiver services and evidence in the PCP/POC that services and supports provide for the participant's health, safety and well being (e.g. risk assessment, crisis plan, backup plan). The plans must include current MR-2s and diagnostic assessments.

Remediation

If it is discovered that an applicant for whom a slot has been identified has had no initial LOC application, the LME contacts the case manager to have the initial LOC evaluation started.

If it is discovered that a participant has no CNR by their birth month, the UR vendor notifies the LME and the LME contacts the case manager to have the CNR completed. In order to continue provision of services, the case manager must request and receive approval from the UR vendor, for services to continue until the CNR is completed.

If it is discovered that an LOC initial packet is incomplete, the UR vendor returns the LOC initial packet to the LME. The LME contacts the case manager who must submit a complete LOC initial packet.

If it is discovered that a participant does not meet ICF-MR/DD LOC criteria, the DMA notifies the DMH/DD/SAS who contacts the LME who contacts the case manager to re-submit an updated LOC packet, so that eligibility may be re-evaluated. If it is ascertained that the participant does not meet eligibility requirements, his/her services will be suspended and non-waiver services will be pursued by the case manager. The participant may choose to initiate the DHHS appeals process.

If it is discovered that a participant does not meet ICF-MR/DD LOC criteria, the DMA will also provide technical assistance to the LOC reviewer to prevent other non-eligible persons from being approved for waiver services in the future.

- **Service Plans**

SPs address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means

In order to ensure that all PCP/POCs address the assessed needs and goals of individual participants, the state uses a variety of methods, including the utilization review of all PCPs/POCs by the UR vendor and a review of a random ample of PCP/POCs by the DMA. DMH/DD/SAS reviews all plans over $85,000, and a conducts a focused review of the transition plans and PCP/POC for all MFP participants. PCP/POC development will be reviewed during the ongoing monitoring process, including determining whether assessments are conducted as required, strategies in the plan address assessed needs, services are being implemented and the case manager is monitoring the plan. Monthly reports will be written by the reviewing agencies.

National Core Indicator data will be collected annually on participant/guardian opinions regarding their satisfaction with the way the PCP/POC meets the needs of the participant. These data, along with data generated by the reviewing agencies, will be aggregated, analyzed and reported by the DMH/DD/SAS QM Team.

Remediation

If the PCP/POC of an MFP participant is found by the DMH/DD/SAS to be out of compliance, the reviewer will notify the UR Vendor and/ or case manager. The UR Vendor will contact the case manager and request that the issue(s) be corrected. The case manager has five (5) days to submit the corrections to the UR vender. The UR Vendor tracks whether the plan is revised in an adequate fashion. DMH/DD/SAS will follow up with the UR Vendor and the case manager to ensure that changes have been made.

The DMH/DD/SAS will review aggregate data on POC compliance to determine to determine any systematic issues and trends. The Division will do a targeted review of aggregate information for people being discharged from state facilities.

The state monitors Person Centered Plan development in accordance with its policies and procedures

The DMH/DD/SAS reviews all MFP participants' PCPs/POCs as well as those plans over $85,000 and the UR vendor reviews all other PCPs/POCs. These reviews determine whether they comport with the state's policies and procedures including any required assessments, timelines, crisis plans, risk assessments, etc. The DMA also conducts monthly reviews of a sample of PCP/POCs. For individuals enrolled in MFP, DMH/DD/SAS staff will review each plan to determine that policies and procedures are honored. In addition, the DMH/DD/SAS Accountability Team reviews PCP/POCs as part of their annual provider reviews to determine whether or not plans meet state guidelines. As part of the LME monitoring of providers, a sample of plans is reviewed during regular monitoring of case management agencies.

Data will be generated by the reviewers based on findings and including the case management agency and LME. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH QM Team.

Remediation

If a state reviewer discovers a plan out of compliance, a plan of correction will be required. The case manager has 5 days to submit the correction. The DMH/DD/SAS or DMA reviewer follows up to ensure the issue was resolved in accordance with the standardized PCP/POC policy.

If the LME finds a plan out of compliance during the provider review, the LME will require a plan of correction and will follow up to ensure that issue is rectified. If the problem persists, the LME can remove the provider's endorsement.

Person Centered Plans are updated/revised at least annually or when warranted when there are changes in the participants needs

The case manager notifies the LME 30 days before the expiration of the PCP/POCs. The UR vendor generates a monthly list of PCP/POCs that were renewed annually and plans that were not updated in a timely fashion. In addition, the DMA monthly review of plans, the LME review of case management agencies, and the DMH/DD/SAS review of providers will also assess whether plans are renewed in a timely fashion and whether plans changed as individual needs changed. For MFP participants, the state will develop a standardized case management tool to canvass any changes in needs during the year. Data will be generated by the reviewers based on findings and grouped by the case management agency and LME. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH/DD/SAS QM Team.

Remediation

When the DMH/DD/SAS identifies a participant who's PCP/POC has not been renewed, staff will contact the LME who will in turn contact the participants' case manager and ask for a plan of correction. Further, if the DMH/DD/SAS Accountability Team, DMA, or LME provider monitoring uncovers individuals whose needs have changed without the appropriate plan revision, the LME will ask for a plan of correction and follow-up would be carried out.

Services are delivered in accordance with the Person Centered Plan, including the types, scope, amount, duration, and frequency specified in the Person Centered Plan.

To ensure that services are delivered as included in the plan, the case manager will use a standardized case management checklist during each monthly face to face interview with the consumer. The checklist will facilitate the case manager's conducting a consistent review on a continuous basis to assure that services are delivered as specified in the PCP/POC. The review includes monitoring provider services, data and time sheets, as well as monitoring the billing. The LME will conduct a review of the case manager's process that will include an annual review of all MFP providers. Data will be generated by the reviewers based on findings and grouped by the case management agency and LME. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH QM Team.

Remediation

If it is discovered that services are not being delivered in accordance with the PCP/POC, the case manager or LME addresses the issue(s) with the provider and works with the provider to resolve the issue. If the provider fails to resolve the issue adequately, the case manager may address the issue with the participant and suggest a change of provider. The provider can be reported to DMA's Program Integrity unit for auditing if warranted. The LME can also revoke the provider's endorsement.

Participants are afforded choice between [CAP-MR/DD] waiver services and institutional care, and between/among waiver services and providers.

The PCP/POC for each participant will include statements attesting that the participant/guardian has been notified of the choice of CAP-MR/DD waiver or institutional care and the choice of CAP-MR/DD waiver services and providers. The participant must sign the statements in order for them to be valid. The PCP/POC cannot be approved without this evidence. The UR vendor and the DMH/DD/SAS reviewer will contact the case manager to request the signed documents. The DMH/DD/SAS reviewer may contact the UR vendor and ask them to request the signed documents for the PCPs/POCs over $85,000. Data will be generated by the reviewers based on findings and including the case management agency and LME. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH/DD/SAS QM Team.

Remediation

If the UR vendor reviewer finds the signature(s) to be missing, the reviewer contacts the LME who contacts the case manager. The DMH/DD/SAS reviewer may contact the UR vendor or the case manager directly and request the appropriate signatures be obtained. The case manager has 5 days to submit the requested documents.

- **Qualified Providers**

The state verifies that providers, initially and continually, meet required licensing and/or certification standards prior to their furnishing waiver services.

The LME initially endorses all providers prior to service provision, but cannot endorse if the provider is found to be out of compliance with any licensing or certification standard. The Division of Health Services Regulations (DHSR) licenses the provider agency, if it meets all licensing requirements. The LME and DMH/DD/SAS Accountability Team monitor the providers on a scheduled basis. Their monitoring includes reviewing the provider's documentation and observing service provision, both of which may indicate whether licensing and/or certification requirements have/are being met. DHSR monitors each licensed provider annually to see if all licensing requirements are being met. Data will be generated by the all reviewers based on findings and including the case management agency and LME. The annual reports will be written by the reviewing agency. The annual aggregate data will be analyzed and reported by the DMH/DD/SAS QM Team.

Remediation

If the LME or DMH/DD/SAS Accountability Team finds an endorsed provider out of compliance with any certification standard, they may require a Plan of Correction (unless the compliance issue may or is endangering participants, in which case the endorsement could be immediately revoked) . The same is true if DHSR finds a licensing issue. The provider has 15 days to submit the plan of correction.

DHSR also conducts an investigation of a licensed provider against whom a complaint has been lodged. Results of the investigation will be shared with DMH/DD/SAS and the person who submitted the complaint. When DHSR finds a licensing compliance issue, they may require a plan of correction, fine the provider, or revoke the provider's license. If a provider's license is revoked, their endorsement to provide services is immediately revoked as well.

After an agency submits a Plan of Correction, the LME or Accountability Team will conduct a follow up review to determine if the provider has corrected the issues. If not, the LME or Accountability Team may require another Plan of Correction. The LME may revoke the provider's endorsement, if the issues are still not corrected. The Accountability Team can also require the provider to reimburse the DMH/DD/SAS and/or Medicaid, if the discovered issues warrant such action.

The state monitors non-licensed/non-certified providers to assure adherence to [CAP-MR/DD] waiver requirements

For non-licensed, non-certified providers, the LME reviews the provider's qualification documents and endorses the provider if all qualifications are met. The LME monitors the provider on an ongoing basis, as does the DMH/DD/SAS Accountability Team. DMH/DD/SAS reviews all MFP participants' PCPs/POCs as well as those plans over $85,000 and the UR vendor reviews all other PCP/POCs. These reviews determine whether plans comport with the state's policies and procedures, including any required assessments, timelines, crisis plans, risk assessments, etc. DMA also conducts monthly reviews of a sample of POCs. In addition, the DMH/DD/SAS Accountability Team reviews PCP/POCs as part of their annual provider reviews to determine whether or not plans meet state guidelines. As part of the LME monitoring of providers, a sample of plans is reviewed as part of the review of case management agencies.

Data will be generated by the reviewers based on findings and including the case management agency and LME. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH QM Team.

Remediation

If the LME or Accountability Team finds the provider out of compliance, they require a Plan of Correction. The LME or Accountability Team will then conduct a targeted monitoring review to determine if the provider has corrected the issues. If not the LME or Accountability Team may require another Plan of Correction. The LME may revoke the provider's endorsement, if the issues are still not corrected. The Accountability Team can also require the provider to reimburse the DMH/DD/SAS and/or Medicaid, if the discovered issues warrant such action.

The state implements its policies and procedures for verifying that provider training has been conducted in accordance with state requirements and the approved waiver

The LME is responsible for monitoring the provider to ensure the provider has documentation to prove all training has been conducted in accordance with state requirements and the approved CAP-MR/DD waiver. This includes, but is not limited to, reviewing First Aid, CPR and medication administration training, as well as training specific to caring for individual participants. This will be vital for the success and safety of the MFP participants. The Accountability Team also reviews for the training documentation.

Data will be generated by the reviewers based on findings and grouped by the case management agency and LME. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH/DD/SAS QM Team.

Remediation

If the LME or Accountability Team finds the provider out of compliance they may require a Plan of Correction. The LME or Accountability Team will then conduct a follow up review to determine if the provider has corrected the issues. If not the LME or Accountability Team may require another Plan of Correction. The LME may revoke the provider's endorsement, if the issues are still not corrected. The Accountability Team can also require the provider to reimburse the DMH/DD/SAS and/or Medicaid, if the discovered issues warrant such action.

- **Health and Welfare**

The state, on an ongoing basis, identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation

The case management monitoring protocol requires that the case manager must conduct a monthly face to face meeting with the participant to discover if all services in the PCP/POC that address health, safety and welfare are being provided according to the plan. The case management monitoring protocol also requires oversight of the participant's health, welfare and safety, including any injuries or other unusual incidents that may have occurred. Prior to or during the PCP/POC meeting, the team, along with the participant/guardian, conducts a risk assessment which is incorporated into the PCP/POC. The PCP/POC must address the identified risks in order that the consumer's risks may be minimized. The PCP/POC must also contain a Crisis Plan, as well as a behavioral plan as needed. The providers must participate in the DHHS incident reporting system. (See Section III.)

Health data from the National Core Indicators surveys is analyzed to ascertain what proportion of participants are receiving adequate health monitoring by doctors and dentists.

Remediation

The case manager must ensure that the Person Centered Plan is kept current with the participant's changing needs. When the case manager discovers that a participant is at risk, s/he must address the issue immediately or in a timely fashion as required. This may include anything from calling a team meeting to address the issue to getting medical care for the participant to seeing that the participant is removed immediately from the environment that has put him or her at risk. If the case manager discovers that the participant has had multiple incident reports submitted for the same or different incidents, s/he must address this with the team or in whatever manner is necessitated by the severity of the incident. The case manager must ensure that the crisis plan and behavioral plans are updated on a continuous basis as the participant's needs change.

The DMH/DD/SAS QM Team will aggregate and review complaint data, incident data, and National Core Indicators data – particularly those questions directed at whether individuals feel safe in their neighborhoods and homes – to examine any trends that suggest health and safety vulnerabilities of CAP-MR/DD waiver participants generally and MFP participants specifically. Troublesome trends will be reported to the LMEs for action and followed up by the DMH/DD/SAS.

- **Administrative Authority**

  The Medicaid agency retains ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of the waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

  DMA's responsibilities include review of reports generated by DMH/DD/SAS and LMEs and review of all policies and procedures and information governing the CAP-MR/DD waiver. The DMA ensures that CAP-MR/DD waiver slot allocations do not exceed approved limits and CAP-MR/DD waiver costs do not exceed estimated costs. DMA reviews participant PCP/POCs to ensure all CAP-MR/DD waiver requirements are met and ensures that CAP-MR/DD waiver services have prior authorization. DMA sets the standards for and oversees the provider enrollment process and all Medicaid provider agreements. With reference to MFP specifically, DMA will communicate any information regarding CMS policies, procedures, and technical assistance opportunities.

  Remediation

  DMA must review all CAP-MR/DD waiver policies, rules, procedures, rates and service definitions prior to their final approval. If DMA has an issue with any item reviewed, they will notify DMH/DD/SAS to correct the issue. If DMA finds an issue with any report they review, they will return it to DMH/DD/SAS and ask for corrections, amendments, more analysis, etc. DMH/DD/SAS will correct the report to DMA's satisfaction. DMA may then opt to conduct a validation review.

IV. Quality Improvement

Development of a quality improvement strategy for the CAP-MR/DD waiver and the developmental disabilities service system as a whole is one of the fundamental building blocks of Mental Health/Developmental Disabilities and Substance Abuse Services transformation in North Carolina. Quality improvement for the MFP participant services will be incorporated into the overall CAP-MR/DD QM system. This quality management system is built around a coordinated approach that defines, assigns and interprets quality related activities across various entities in the system. According to federal and state guidelines the DMA has responsibility for the overall operation of the CAP-MR/DD waiver. The DMH/DD/SAS is the lead agency overseeing the daily operations of the CAP-MR/DD waiver. The two Divisions cooperate in the operation of the CAP-MR/DD waiver program under a memorandum of understanding that delineates each division's responsibilities

The quality improvement strategy for the CAP-MR/DD waiver includes identification and regular reporting on performance measures that are accepted by the program managers and stakeholders, several committees responsible for reviewing patterns and trends to identify and build on successes and to address problems as they emerge, and processes for developing and implementing plans for improvement of service quality. Evaluation of the QI strategy will be done through self accountability, oversight by the DMH/DD/SAS and DMA leadership and through communication to and feedback from key stakeholders.

- **Quality Improvement Committees**

  The State MH/DD/SAS has developed a quality management plan that integrates and analyses information from multiple sources and functions within the state system. The plan brings together partners and stakeholders, including consumers/families, provider agencies, LME representatives and representatives from the different parts of the State system. Following is a description of the major oversight/quality improvement committees:

  - **Internal Quality Management Committee (IQMC)**

    DMH/DD/SAS and DMA will establish the IQMC comprised of the members of the DMH/DD/SAS QM Team and other DMH/DD/SAS teams, and representatives from the DMA. The IQMC will be convened quarterly as part of the QM plan.

    This committee will work to support and encourage systematic quality management systems and consistent expectations for all MH/DD/SAS consumers, including the MFP participants. The responsibilities of the IQMC include:

    - Review QA/QI system data received from the responsible entities/agencies. The committee shall review the data at a minimum quarterly. Meetings shall be scheduled one time per calendar quarter. Meeting minutes shall be kept at all workgroup meetings.
    - Analyze data to determine patterns, trends, problems, and issues in service delivery of waiver services.
    - Make recommendations to the CAP-MR/DD Waiver program managers for changes in policy based on analysis of compiled QA/QI data.
    - Direct LMEs to provide training, technical assistance, or other activity, based on analysis of QA/QI data. Monitor the activity to assure consistent implementation statewide.
    - Continue to develop and refine the QA/QI quality indicators to be monitored.
    - Review and make changes to the QA/QI plan as needed to assure that the data gathered is generating useful information to improve quality of service delivery. At a minimum the plan shall be reviewed annually.
    - Review and modify the QA/QI policies and procedures as needed. At a minimum this shall occur annually
    - Disseminate information compiled from analysis of QA/QI data to appropriate stakeholders, including consumers, family members and system advocates.

  - **Consumer and Family Advisory Committees**

    Each LME is required by legislation to establish a Consumer and Family Advisory Committee (CFAC) made up of adult consumers and family members of consumers. Local CFACs are self-governing and self-directing bodies that advise the LME on the planning and management of the local public MH/DD/SAS system. Local CFACs undertake the following:

- Review, comment on, and monitor the implementation of the LME's local business plan.
- Identify service gaps and underserved populations.
- Make recommendations regarding the service array and monitor the development of additional services.
- Review and comment on the LME program budget.
- Participate in all quality improvement measures and performance indicators.
- Submit to the State CFAC findings and recommendations regarding ways to improve the delivery of MH/DD/SA services.

In addition, DMH/DD/SAS is required by legislation to establish a state CFAC, comprised of seven appointed members representing each of the three disabilities (21 total members). The State CFAC is a self-governing body that is responsible for carrying out at a statewide level the same activities as the local CFACs. In addition, the State CFAC is responsible for the following:

- Receive the findings and recommendations from local CFACs regarding ways to improve the delivery of mental health, developmental disabilities, and substance abuse services.
- Submit to the DMH/DD/SAS findings and recommendations regarding ways to improve the delivery of MH/DD/SA services.
- Provide technical assistance to local CFACs in implementing their duties.

o **MFP Advisory Group**

An MFP advisory group will be formed to review aggregate reports and make recommendations for improvement. This group will be comprised of 60% consumers and/or their families and 40% providers/advocates and other stakeholders. This group will meet at least four to six times per year to review the MFP data and processes and provide remediation suggestions. Recommendations will be reviewed and acted on by the IQMC.

o **Other DMH/DD/SAS Internal Groups:**

- The **Executive Leadership Team (ELT)** is comprised of the DMH/DD/SAS Directors and Section Chiefs, Personnel Manager, and the representative from the State Attorney General's Office and meets weekly. It is responsible for providing strategic and operational leadership for the service system, setting overall policy direction, and approving all Division policy changes and initiatives.
- The **Clinical Oversight Team (COT)** is comprised of DMH/DD/SAS staff with expertise in the three disability areas (MH, DD and SA) and staff with quality management responsibilities. It meets weekly to review trends in service utilization, consumer safety, and complaints, to address clinical issues arising from the field, and to propose needed clinical policy changes.

- The **Transformation Strategy Group (TSG)** is comprised of mid-level DMH/DD/SAS management staff and meets weekly. It is responsible for responding to legislative mandates, chartering cross-team workgroups to develop and implement initiatives to improve the service system, and ensuring timely completion of assigned initiatives. It monitors progress toward system improvement goals and legislative requirements.

o **Cross-Division and Stakeholder Groups:**

- The **External Advisory Team (EAT)** is comprised of representatives of LMEs and provider associations for each of the three disabilities and meets monthly. It is charged with advising the DMH/DD/SAS on proposed policy changes and emerging issues regarding the coordination and management of the service system.
- The **Local Management Entity Advisory Group (LAG)** is made up of representatives of the LMEs and meets monthly. It is charged with providing input from the perspective of LMEs on proposed changes in DHHS policies and operations, as they involve local management and oversight of the service system.
- The **Provider Action Agenda Committee (PAAC**) is made up of representatives of service provider agencies across the three disabilities. It meets monthly to discuss statewide issues that affect the provision of services and make recommendations to the DHHS for changes in policies and operations.
- The **Advisory Stakeholder Group (ASG)** is comprised of 60% consumers and/or their families and 40% providers/advocates. This group will meet four to six times per year to discuss and make recommendations on Medicaid policies and operations.

- **Performance Measures and QI Reports**

  The CAP-MR/DD waiver includes QA/QI indicators that capture the activities above. Each indicator also includes the type and frequency of activities for gathering data specific to the indicator, the sampling methods for each indicator, how data will be collected, who will collect the data, and acceptable thresholds for each indicator. Through the analysis and review of process indicators, deviations from expected trends will be identified for further analysis and study. If applicable, special studies will be undertaken on prioritized measures to understand changes in trends.

  Using the reports on the performance indicators from the CAP-MR/DD waiver and trend analysis of these and other reports, and observations by the CAP-MR/DD waiver team, consumers, families and service providers, the IQMC will set targets for quality and uniform services and develop improvement strategies as needed. There will be alerts set to ascertain when things are going right or wrong. When a problem is identified, the IQMC will facilitate an evaluation to find the source, after which, the CAP-MFP program managers will develop a remediation plan, if needed and assign implementation and follow-up to the appropriate staff.

V. Evaluation of the Quality Management System (QMS)

The IQMC will evaluate the performance of the QMS annually, including its own performance in achieving the specific responsibilities described above. The evaluation will include a continual review of the quality improvement initiatives implemented by the IQMC. The IQMC

will assess the success of the processes undertaken for the monitoring the system. The IQMC process measures would include, but not be limited to, frequency of the meeting, the ability of the group to meet targets of the work plan, and timely review and mitigation of relevant measures. In addition, the IQMC will:

- Gather member input on how well the QMS is functioning and will make ongoing changes to internal processes, as needed to improve the effectiveness of the committee and its initiatives.
- Conduct an annual survey of members, other staff, and partners to gather perceptions of the QA/QI process and possible improvements.
- Review and modify the QA/QI policies and procedures as needed. At a minimum this shall occur annually based on the results of the partners survey and other information which are used to determine 1) adherence to current QA/QI policies and procedures, 4) usefulness of the quality indicators and other data used to monitor service delivery, and 3) effectiveness of the QA/QI process in improving care.

The DMH/DD/SAS Executive Leadership Team will approve the QM Plan and periodically review the status of the performance measures and the corrective processes undertaken by the IQMC.

Attachment I

North Carolina
Quality Management Strategy for Money Follows the Person
Program of All-inclusive Care for the Elderly (PACE)

June 10, 2008

I. Introduction and Purpose

The purpose of the Quality Management Plan is to ensure discovery processes and systems for remediation and Quality Improvement take into consideration the specific and unique needs of elderly and/or disabled individuals choosing to live in their community and home. This shall include oversight of the success of the transition process, successes and barriers experienced in community living, effectiveness of back-up systems, and risks that might lead to re-institutionalization.

North Carolina is aware that the *Money Follows the Person* initiative occurs within the state's overarching Quality Management System for home and community based waiver services. To the degree possible it will enable data collection across all waiver and *Program of All-inclusive Care for the Elderly* participants and compare data between *Money Follows the Person* and non-*Money Follows the Person* participants. While the *Program of All-Inclusive Care for the Elderly* is a state plan service and not a waiver service, it is just as essential to provide a quality management program that addresses many, if not all of the same aspects as those in the HCBS Waiver Programs.

The *Program of All-inclusive Care for the Elderly* model is centered on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible.

The *Program of All-Inclusive Care for the Elderly* serves individuals who are age 55 or older, determined by the state to need nursing facility level of care, are able to live safely in the community at the time of enrollment, and live in a *Program of All-Inclusive Care for the Elderly* service area. Even though all *Program of All-Inclusive Care for the Elderly* participants must be determined to need nursing facility level of care to enroll in *Program of All-Inclusive Care for the Elderly*, only about seven percent of *Program of All-Inclusive Care for the Elderly* participants (nationally) reside in nursing facilities. If a *Program of All-Inclusive Care for the Elderly* enrollee does need nursing facility care after enrollment, the *Program of All-Inclusive Care for the Elderly* program pays for it and continues to coordinate the enrollee's care.

Delivering all needed medical and supportive services, the program is able to provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as possible. Care and services include but are not limited to:

- Adult day care that offers nursing; physical, occupational and recreational therapies; meals; nutritional counseling; social work and personal care
- Medical care provided by a Program of All-Inclusive Care for the Elderly physician familiar with the history, needs and preferences of each participant

- Home health care and personal care
- All necessary prescription drugs
- Social services
- Medical Specialists such as audiology, dentistry, optometry, podiatry, and speech therapy
- Respite care
- Hospital and nursing home care when necessary

North Carolina's first *Program of All-Inclusive Care for the Elderly* is the Elderhaus program. It became operational on February 1, 2008 in Wilmington and has four enrollees at this time. A second *Program of All-Inclusive Care for the Elderly* program run by Piedmont Health Services is scheduled to begin operation this fall in Burlington NC. A third *Program of All-Inclusive Care for the Elderly* program run by St. Joseph of the Pines is developing a *Program of All-Inclusive Care for the Elderly* application for a program in Fayetteville NC with a likely start date of early to mid 2009. North Carolina's *Program of All-Inclusive Care for the Elderly* programs are in their infancy and receive frequent and ongoing monitoring and assistance from the North Carolina Division of Medical Assistance (DMA) and the North Carolina Division of Aging and Adult Services. North Carolina Division of Medical Assistance recognizes the need for continuous monitoring and evaluation of developing and existing *Program of All-Inclusive Care for the Elderly* programs and the need for ongoing and fluid collaboration with the staff of each *Program of All-Inclusive Care for the Elderly* program and the Centers for Medicare and Medicaid Services as these programs continue to develop and evolve. The Division of Medical Assistance has a full-time *Program of All-Inclusive Care for the Elderly* Program Manager to assist with the development and maintenance of all Program of All-Inclusive Care for the Elderly programs in North Carolina.

II. Roles and Responsibilities for Oversight and Quality Improvement *While the example provided below is specific to the Elderhaus PACE Center, it is expected that all PACE centers will have plans that address the same elements. PACE centers work in collaboration with North Carolina Division of Medical Assistance and Centers for Medicaid staff to ensure the development and implementation of a high quality management program.

The Quality Assurance Performance Improvement Plan applies to all services provided by medical staff, employees, volunteers, contractors and others affiliated with Elderhaus *Program of all Inclusive Care for the Elderly*.
Responsibility for quality assessment and performance improvement ultimately rests with the organization's governing body, the Board of Directors for Elderhaus, Inc. This governing body has the final authority to commit adequate resources and create a culture to support Quality Assurance Performance Improvement efforts. The governing body will:

1. Activate the organization's mission by continually improving the quality of participant care and services;

2. Incorporate findings from quality assessment and improvement activities in strategic, program, and resource planning;

3. Provide guidance toward continuing education concerning the approach, methods, tools, and application of continuous quality improvement;

4. Establish broad guidelines for quality improvement activities in conjunction with the Elderhaus *Program of all Inclusive Care for the Elderly* Management Team;

5. Guide process analysis and improvement;

6. Provide for and review an annual evaluation of the performance of the Elderhaus *Program of all Inclusive Care for the Elderly* Quality Assurance Performance Improvement Program.

The Elderhaus *Program of all Inclusive Care for the Elderly Management Team* provides oversight of all Elderhaus Program ACE Quality Assurance Performance Improvement activities. The Elderhaus *Program of All inclusive Care for the Elderly Quality Improvement Coordinator* will be responsible for ensuring that quality data are collected from all appropriate sources, that the data are examined and that results are shared with all appropriate staff and/or committee members for follow-up action. The Quality Improvement Coordinator will produce an annual Quality Management Summary to be reviewed with the Management Team and passed up to the Elderhaus *Program of all Inclusive Care for the Elderly* Board of Directors. This report will also be submitted to the Division of Medical Assistance.
The Division of Medical Assistance *Program of All-Inclusive Care for the Elderly* Program Manager provides prior approval through the State's standardized assessment tool (currently the FL-2 form) process. This process includes an initial review of each participant's assessments and service plan. Service plans and related assessments are reviewed annually or as revisions are necessary. The *Program of All-Inclusive Care for the Elderly* Program Manager performs each *Program of All-Inclusive Care for the Elderly* program's site readiness reviews for CMS which includes compliance with local, state, and federal authorities pertaining to the policy and operation of each program. All *Program of All-Inclusive Care for the Elderly* programs are required to have Adult Day Health Care certification which is a provision of the Division of Aging and Adult Services. The Quality Assurance Performance Improvement Plan and the requirements for the "State Administering Agency" (NC DMA) are further detailed in the Three Party Program Agreement between the *Program of All-Inclusive Care for the Elderly* Center, the North Carolina Division of Medical Assistance and the Centers for Medicare and Medicaid Services. (See also Appendices K, Q, R, and S).

III. CMS Assurances

Level of Care

North Carolina Medicaid requires that a level of care determination be made on all participants seeking home and community based services, including the *Program of all Inclusive Care for the Elderly*, by using a standardized screening tool (currently the FL-2 form) for determining nursing facility level of care. Procedures exist to assure that individuals reflect nursing facility level of care after a complete assessment. Level of care is re-evaluated annually.

Service Plan – Plan of Care (includes oversight of back-up plans and risk planning and mitigation)

Service Plans address all participants' assessed needs (including health and safety risk factors) and personal goals that are provided by the *Program of All-Inclusive Care for the Elderly* Center
The state monitors the Service Plan development in accordance with CMS and North Carolina's policies and procedures
The Service Plan is updated / revised at least annually or when warranted when there are changes in the participants needs
Services are delivered in accordance with the Service Plan, including the types, scope, amount, duration, and frequency specified in the Service Plan
Participants are afforded choice between *Program of All-Inclusive Care for the Elderly* services, institutional care, waiver services, and state plan services.
Service Plan assurances are monitored by the *Program of All-Inclusive Care for the Elderly* Program Manager through monthly contacts and site visits which occur at no lesser interval than quarterly.

Qualified Providers
The state verifies that providers, initially and continually, meet required licensing and/or certification standards prior to their furnishing services
The state monitors non-licensed/non-certified providers to assure adherence to Federal *Program of All-Inclusive Care for the Elderly* and North Carolina criteria and requirements.
The state implements its policies and procedures for verifying that provider training has been conducted in accordance with state requirements and the approved waiver

Health and Welfare
The state, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation. All incident reports are provided to the *Program of All-Inclusive Care for the Elderly* Program Manager for review. This includes reports of critical incidents. Reports are reviewed to ensure that appropriate action was taken at the time of the incident, whether further investigation is needed, and if further action or training may be required to ameliorate and/or prevent any recurrence of the incident.

Administrative Authority
The North Carolina Division of Medical Assistance shares authority and responsibility for the operation of *Program of All-Inclusive Care for the Elderly* programs with the Centers for Medicare and Medicaid Services. North Carolina Division of Medical Assistance exercises oversight over the performance of each *Program of All-Inclusive Care for the Elderly* program. Any deficiencies identified by the State Administering Agency's *Program of All-Inclusive Care for the Elderly* Program Manager are shared with CMS *Program of All-Inclusive Care for the Elderly* staff.

Critical Incident
The state, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation. All incident reports are provided to the *Program of All-Inclusive Care for the Elderly* Program Manager for review, including critical incident reporting. Reports are reviewed to ensure that appropriate action was taken at the time of the incident, whether further investigation is needed, or if further action or training may be required to ameliorate and/or prevent any recurrence of the incident.

Each Program *of All-Inclusive Care for the Elderly* Center is required by CMS to report all critical incidents to CMS. All information provided to CMS is also submitted to the North Carolina *Program of All-Inclusive Care for the Elderly* Program Manager for review.

Risk Management

Diagnoses and symptoms that pose a significant risk to health, safety, and well-being of each *Program of All-Inclusive Care for the Elderly* participant are identified during an on-going interdisciplinary assessment process that is very thorough and comprehensive. Each risk identified by the assessment process must be addressed in the individual's service plan. For example, an individual identified with a fall risk may need to have assistance while ambulating through the use of gait belt, or, an individual with a history of bowel obstructions may require a more thorough monitoring of bowel movements and/or a specialized diet to help prevent hospitalizations. Since *Program of All-Inclusive Care for the Elderly* Centers serve a significant number of individuals with cognitive impairments and/or dementia, wandering and elopement is often an issue. Any individual identified with a dementia-like diagnosis is monitored using a Wander-guard system. The North Carolina *Program of All-Inclusive Care for the Elderly* Program Manager will monitor Service Plans with special consideration given to diagnoses and symptoms where risk is more inherent and evaluate if these risks are addressed adequately. Any service plan that is deficient in this regard must be amended before approval. Additionally, any interventions designed to minimize risk will be assessed during site reviews to assure they are functioning and are being implemented as designed and intended.

24 Hour Back Up

While the need for 24/7 care coverage is assessed and addressed in each participant's service plan, including a back up plan for needed care coverage that includes formal and informal supports, there are times when the most comprehensive plans can be insufficient. For this reason, each *Program of All-Inclusive Care for the Elderly* center is required to have a 24/7 on-call staff person who is able to assist any *Program of All-Inclusive Care for the Elderly* participant who is in a crisis or emergency who needs to obtain access to critical medical supports. The *Program of All-Inclusive Care for the Elderly* participant, their legal (as applicable) and family members are informed of how to access the 24/7 on-call system during intake and assessment, and in their service plan. This information is reviewed on an annual basis and as needed with each participant. The on-call person is either a physician or registered nurse. The *Program of All-Inclusive Care for the Elderly on-call staff* documents all calls taken during the center's non-operational hours and the action taken to address the participant's issue or problem. The call and resulting action is also documented in the participant's record. It is the responsibility of the *Program of All-Inclusive Care for the Elderly* Program Manager to monitor the *Program of All-Inclusive Care for the Elderly* Center to ensure the 24/7 system is working and that 24/7 coverage needs are identified and addressed adequately and in a timely manner. The Division of Medical Assistance *Program of All-Inclusive Care for the Elderly* Program Manager reviews monthly reports of calls to the center's 24/7 system and provides feedback as necessary related to any improvements in the handling of calls to this system.

IV. Evaluation of the Quality Management - *While the example provided below is specific to the Elderhaus PACE Center, it is expected that all PACE centers will have plans that address the same elements. PACE centers work in collaboration with

North Carolina Division of Medical Assistance and Centers for Medicaid staff to ensure the development and implementation of a high quality management program.

Implementation

Key to implementing the Quality Assurance Performance Improvement plan is having a system in place to regularly and systematically collect, record, and report data.

- Selected aggregated outcomes data will be reviewed for trends, patterns and opportunities for improvement.
- Variation in outcomes will be evaluated from both the program and the individual participant perspective.
- When practice variations are identified, a plan will be developed and implemented to identify more effective practices whenever possible.
- The Quality Assurance Performance Improvement plan will use standard data measures developed by such organizations as the National *Program of all Inclusive Care for the Elderly* Association whenever possible and those specified by CMS and the State administering agency as specified (in accordance with §460.140). Professional standards of Elderhaus *Program of all Inclusive Care for the Elderly* staff will be measured against those outlined by their respective licensing agency in the state of North Carolina (e.g. The North Carolina Board of Nursing). When published guidelines do not appropriately address the Elderhaus *Program of all Inclusive Care for the Elderly* population, internal standards inferred by available data may be developed.
- The Elderhaus *Program of all Inclusive Care for the Elderly* Management Team will identify both problems and areas of outstanding performance.
- The organization will monitor staff and contractors to ensure appropriate standards of care are met and appropriate training and credentialing are maintained. Service delivery will be monitored through feedback from staff, participants, and family members during daily staff meetings, care plan reviews, and meetings with families.
- The organization will monitor performance in non-clinical areas. Examples include problems identified during fire drills or problems with timeliness of transportation. All participants will be educated about the grievance process and grievances will be monitored for opportunities to improve future performance.
- Enrollment and disenrollment data, particularly reasons for disenrollment, will be reviewed at least quarterly and compared with benchmarks set against other *Program of all Inclusive Care for the Elderly* programs.
- Monitoring of Occurrences. Review of occurrence reports will be used to monitor possible problems with safe practice, maintaining a safe environment, or protecting participants' rights. Occurrence reports may result from:
    - Abuse or suspected abuse
    - Participant elopement
    - An outbreak of a communicable disease
    - Occurrences involving police or fire department
    - Theft or vandalism of property at Elderhaus *Program of all Inclusive Care for the Elderly* or at contract providers working with Elderhaus *Program of all Inclusive Care for the Elderly*
    - Falls
    - Accidents

    - Potential for injury
    - Medication administration errors or medication adverse reactions
    - Other unusual occurrences
- Prevention of Fraud, Waste, and Abuse: Elderhaus *Program of All-inclusive Care for the Elderly* will participate in the National *Program of All-inclusive Care for the Elderly* Association sponsored evaluation and procedure development being implemented to address monitoring and audit requirements under the new Part-D Medicare regulations. As findings and tools become available, they will be incorporated into the Quality Improvement Performance Improvement process.
- Data Integrity: Elderhaus *Program of all Inclusive Care for the Elderly* will monitor its data collection processes for timeliness, completeness, and accuracy. Tracking and trending may identify problems with data as may periodic spots checks. Identified problems with data collection will be treated as opportunities to improve performance.

Improvement Process

Corrective actions and outcomes resulting in best practices will be incorporated into Elderhaus *Program of all Inclusive Care for the Elderly* polices and procedures.

- Role of the Quality Improvement Coordinator. The Quality Improvement Coordinator is responsible for assuring that the data collected and reported are accurate, timely and complete. The Quality Improvement Coordinator will assist in performing the appropriate statistical analyses to assure consistency and ease of presentation and review. The Quality Improvement Coordinator will assist in detecting trends, patterns, and opportunities for improvements as well as potential problems. In addition, the Quality Improvement Coordinator, along with the Intake Coordinator and the Center Manager, submit monthly data to data entry personnel both in manual and electronic format on data collection tools such as the "Inpatient and Emergency Services Utilization" form completed by the Center Manager. Elderhaus *Program of all Inclusive Care for the Elderly* data entry personnel enters HPMS *Program of all Inclusive Care for the Elderly* data electronically no less frequently than quarterly.
- Peer review for clinical staff. Peer review will be conducted under the direction of senior staff. Interdisciplinary team members will not be responsible for reviewing care for which he/she is responsible. When only one discipline representative is on staff, practice will be reviewed within the expertise of the department. In cases where there is no individual with expertise in that field in the organization, provisions will be made to have care evaluated by an outside expert in the discipline.
- Review for non-clinical staff. When outcomes involve non-clinical staff, review will be conducted under the supervision of appropriate supervisory staff. Outcomes identified through quality management projects will be reevaluated as needed to determine if corrective steps improved outcomes.
- Corrective Action Plans. When opportunities for improvement are identified, a corrective plan will be created. Each corrective plan will include: an explanation of the problem, who is responsible for implementing the corrective plan, the time frame for each step of the plan, and an evaluation process to determine effectiveness. The Management Team will develop Corrective Action Plans related to global problems,

implement those plans, and evaluate their effectiveness. Corrective Action Plans from contracted providers will be requested by the QIC or other member of Management Team, as appropriate. Internal Action Plans will also be generated by the QI Committee and documented via committee minutes.

- Priority Setting. The Management Team, in consultation with the Elderhaus *Program of all Inclusive Care for the Elderly* Program Director, Quality Improvement Coordinator, staff and participants, determines priorities for performance improvement at least annually. Priority will be based on severity, frequency, prevalence, and relevance to outcomes and feasibility of implementation. Priorities are communicated to the Board of Directors for approval.
- Urgent Corrective Measures. Problems that are found to threaten the immediate health and safety of participants or staff will be reported immediately to the Elderhaus *Program of all Inclusive Care for the Elderly* Director. The appropriate staff and the Quality Improvement Coordinator will consult with relevant Elderhaus *Program of all Inclusive Care for the Elderly* staff and be responsible for developing an appropriate corrective plan within 24 hours. Urgent corrective measures will be discussed during morning meeting and, when appropriate, with participants. Disciplinary action and/or the use of appropriate community resources such as Adult Protective Services, notification and cooperation with law enforcement agencies, emergency placement of participants, or other actions will be implemented immediately. The Quality Assurance Performance Improvement plan and relevant policies and procedures will be amended to ensure the health and safety issues identified have been addressed.
- Orientation of Staff and Contract Providers. All new staff members are introduced to the Quality Assurance Performance Improvement plan and Quality Assurance Performance Improvement concepts during their orientation. Results of Quality Assurance Performance Improvement -identified benchmarks are shared with staff annually. Staff may be surveyed for new areas of improvement and reminded that they can bring issues to the Quality Improvement Committee or Management Team annually.
- Orientation of New Elderhaus *Program of all Inclusive Care for the Elderly* Participants and their Families. New Elderhaus *Program of all Inclusive Care for the Elderly* participants and their families are informed during the enrollment process of participants' rights, protection of health information, the grievance and appeals processes, and other methods of voicing satisfaction or dissatisfaction with program services. They are encouraged to give both positive and negative feedback to program staff.

Attachment J

NORTH CAROLINA RISK ISSUE IDENTIFICATION TOOL

Name of Individual:	**Date Completed:**
Individual's Support Coordination Agency:	
Name of Person Completing This Form & and Relationship to the Individual	

I. Identify Risk Issues

Situational (situations, systemic issues, mental health issues, or circumstances with caregivers, family, friends, or others that create the potential for risk)

✓	**Risk Issue**	**Why is this issue of particular risk to this person?**	
		Current	Within five (5) Years
	Loss of caregiver or close family member		
	Loss of someone significant		
	Loss of natural supports		
	Social isolation by caregiver		
	Refusal of critical services (by the individual or the guardian)		
	Unavailable or unreliable staffing		
	Significantly compromised hygiene or appearance (especially if a change from usual)		
	Incapacitated caregiver		
	History of abuse or neglect		
	Pregnancy and parenthood		
	Compromised communication skills		
	Loss of home		
	Eviction		
	Frequent moves for seemingly unjustified reasons		
	Difficulties with relationship with landlord		
	Dangerous or threatening neighbors		

Environmental (environmental issues that create the potential for risk)

✓	**Risk Issue**	**Why is this issue of particular risk to this person?**	
		Current	Within five (5) Years
	Unsanitary living conditions		
	Home is in significant disrepair		
	Necessary environmental modifications not completed		
	Necessary equipment in disrepair, broken, or is lost		
	Unmet equipment needs		
	Equipment not being available for use		

Behavioral (personal behaviors or lifestyle choices that are considered dangerous or potentially dangerous to self or pose a risk to others)

✓	Risk Issue	Why is this issue of particular risk to this person?	
		Current	Within five (5) Years
	Self injury		
	Aggression or violence towards others		
		Current	Within five (5) Years
	Assault		
	Stealing		
	Excessive self-stimulatory behaviors		
	Making significant threats to the safety of others		
	Destruction of property		
	Refusal of necessary services		
	Poor compliance with treatments or supports		
	Elopement		
	Social isolation		
	Compromised communication skills		
	History of poor decision making despite being well-informed		
	Risky sexual behaviors		
	Predatory behavior		
	Excessive fascination with children or sexual abuse of children		
	History of sexually aggressive or dangerous behaviors		
	Fascination with fire or history of fire setting		
	Frequent job changes		
	Suicidal ideation or attempt		
	Substance abuse		
	Contacts with EMS or law enforcement (i.e. unnecessary calls to or create situations to cause others to call)		
	Criminal justice involvement		
	Multiple requests for crisis services		

Medical (health-related risks)

✓	Risk Issue	Why is this issue of particular risk to this person?	
		Current	Within five (5) Years
	Multiple medical or psychiatric hospitalizations in a year		
	Multiple visits to the emergency room (whether admitted or not)		
	A person living alone or with little support who takes multiple medications		
	Taking three or more medications for a chronic medical condition, including a psychiatric diagnosis with reduced supports		
	Medical benefit loss		
	Poor follow through on post hospitalization discharge orders		
	Significant change in health or mental status		
	Significant changes in sleeping or eating patterns		
	Significant number of medical visits or a significant increase in medical visits		
	Unmet medical needs (i.e. appointments not		

Medical (health-related risks)			
✓	**Risk Issue**	**Why is this issue of particular risk to this person?**	
	scheduled, follow-up appointments missed)		
		Current	Within five (5) Years
	Information shared with medical personnel by support staff is inadequate (i.e. reason for referral)		
	Poor compliance or non-compliance with medical regime		
	Refusal of services		
	Inability to tolerate a medical examination/procedure		
	Multiple falls/fractures		
	Mobility impairment		
	Significant weight gain or loss		
	Swallowing disorders		
	History of choking and/or aspiration		
	Skin breakdown		
	Obesity		
	Compromised communication skills (especially in relation to being able to indicate physical pain)		
	Pica		
	Lifestyle choices that negatively affect health (i.e. smoking, drinking when contraindicated by medications)		

Financial risks (mismanagement of finances by self or others or loss of income)			
✓	**Risk Issue**	**Why is this issue of particular risk to this person?**	
		Current	Within five (5) Years
	Loss of job		
	Loss of benefits or significant reduction in benefits		
	Indebtedness		
	Loaning money to others		
	Excessive gambling		
	Financial exploitation		
	Excessive housing costs		

Other risks (identified risks not otherwise mentioned above)			
✓	**What is the Issue?**	**Why is this issue of particular risk to this person?**	
		Current	Within five (5) Years

II. Summary of Incident Reports

Reportable Incidents (summarize by type of incident, the number of reportable incidents, or attach other printout summary of reportable incidents)		
Type of Incident	**Number of Incidents**	**Comments**

Other explanatory Information:

Individuals participating in the completion of this tool:

_____

_____

_____

_____

_____

Attachment K

Qualified Residences for North Carolina Money Follows the Person Participants				
Type of Qualified Residence	**Number of Each Type of Qualified Residences***	**State of Definition Housing Settings & Number of Each**	**Number of Each Settings***	**How Regulated**
Home owned or leased by individual's family member	114	• Home leased by individual or family • Home owned by individual • Home owned by family	• 65 • 0 • 49	• Lease with landlord • N/A • N/A
Apartment with an individual lease, lockable access & egress, & which includes living, sleeping, bathing, & cooking areas over which the individual or the individual's family has domain & control.	177	• Apartment building • Assisted living: multi-unit assisted housing with services • Public housing units • Rural Development Apartment • Housing Credit unit • Supportive housing unit	• 0 • 55 • 10 • 12 • 75 • 25	• Lease with private landlord • Lease with private landlord and HC Voucher • Lease with Public Housing Agency • Lease with RD • Lease with landlord w/HC Voucher • Lease with landlord and Key assistance • Lease with landlord
Residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside (Non-Intermediate Care Facility-Mental Retardation facility).	13	• Supervised Living • Alternative Family Living • Family Care Home	• 2 • 4 • 7	• State122C licensing regulations • 131D licensing regulations

***** NOTE: These are projections only. Projections are based upon limited knowledge of local housing resources and no knowledge of participants' needs or preferences.

Attachment L

LINDA M. HICKS

4325 Whisperwood Drive
Raleigh, North Carolina 27616
919-412-4310
lindamhicks@gmail.com

EXPERIENCE

March 25, 2008 – present Dept. of Health and Human Services Raleigh, NC

Project Director

- Manage Money Follows the Person demonstration grant for the state of North Carolina.

May 15, 2005 – March 21, 2008 Durham's Partnership for Children Durham, NC

More at Four Program Manager

- Coordinated all aspects of More at Four (MAF) program in Durham county.
- Monitored compliance to State and local MAF Guidelines and Requirements.
- Coordinated collaborative efforts with community agencies serving children and families which have an impact on MAF program (health agencies, family support agencies, local Head Start grantee, etc.).
- Coordinated training and technical assistance.
- Supervised staff of two fulltime employees, social work intern (when applicable), temporary employees, and contract personnel.
- Strategic planning for MAF program, county pre-kindergarten programs, and the organization based on results of evaluations and needs assessments.

May 2001 – May 2005 East Coast Migrant Head Start Project Raleigh, NC

Program Monitor

- Monitored Delegate Agencies and Direct Service programs in adherence to the Head Start Performance Standards and contract compliance (Delegate Agencies).
- Strategic planning for organization based on monitoring results, evaluations, and needs assessments (conducted annually).
- Provided training and technical assistance for program self-assessment, monitoring systems, and development of department manuals, policies and procedures.
- Assisted in the design and content of the departmental Monitoring manual.

50% travel along the East Coast of USA.

Sept. 1999– April 2001 Wake County Smart Start Raleigh, NC

Quality Enhancement Specialist

- Provided early childhood technical assistance to childcare programs in Wake

County.

- Coordinated quarterly childcare conferences hosted by agency; led workshops.
- Evaluated programs using the ITERS and ECERS.

EDUCATION

1979–1983 University of Montevallo Montevallo, AL

- B.S., Early Childhood Education.

2002 – October 2003 University of Phoenix, Online Phoenix, AR

- M.A., Organizational Management.

ACCOMPLISHMENTS, OTHER

Obtained NAEYC accreditation while at Washington St. United Methodist Church Child Development Center (1995)

Obtained CITA accreditation for Garner, NC center while at Sylvan Learning Center (1999)

Trained trainer in the TouchPoints model (T. Berry Brazelton, MD) (2000)

Environmental Rating Scales (ECERS, ITERS) training—3-day course (2001)

Office of Head Start PRISM Reviewer (2002 –present)

Facilitator—Wake Education Summit (2004); Durham Public Education Network (2007) and various community functions related to position at Durham's Partnership for Children

Trained trainer (2 day course)—Foundations: NC Early Learning Standards (2006)

A t t a c h m e n t M

TITLE:
Money Follows the Person Program Specialist

SCOPE OF WORK:
To analyze and interpret data, assess federal and state regulations, rules and provider contracts, for use in developing and managing the Money Follows the Person (MFP) project's strategic plan.

ACCOUNTABILITIES:
Manage the Money Follows the Person (MFP) project strategic plan and assist with project management.

Serve as the liaison to the local and state agency's Transition Coordinators.

Research, develop and draft protocols and outreach materials, including the person-centered-planning process, for the Transition Coordinators.

Coordinate education, outreach and training activities for staff, other agencies, advisory councils and community providers.

Make formal presentations to appropriate state bureaus, nursing facilities, community agencies, advisory and planning councils to build strong collaborations, to implement and improve policies and protocols.

Analyze and interpret reports from Transition Coordinators and other relevant reports; make recommendations for improvement to the Project Director.

Consult with associated groups and agencies to ensure coordination in the development and implementation of the project's strategic plan.

Provide information to nursing facilities regarding the goals and expectations of the project.

Produce regular reports as required by the MFP grant and the Project Director.

Perform other duties as required by the Project Director.

MINIMUM QUALIFICATIONS

Education: Bachelor's degree from a recognized college or university with a major study in a field relevant to adults with disabilities. Each additional year of approved formal education may be substituted for one year of required work experience.

Experience: Four years' professional or paraprofessional experience in a field or occupation relevant to services provided by and protocols in the Department of Health and Human Services, Division of Medical Assistance with responsibility for program implementation, direct service delivery, planning or program evaluation. Each additional year of approved work experience may be substituted for one year of required formal education.

License/Certification: Valid driver's license and/or access to transportation for use in statewide travel.

DISCLAIMER STATEMENT: The job description lists the essential functions of the position and is not intended to include every job duty and responsibility specific to the position. An employee may be required to perform other related duties not listed on the supplemental job description provided that such duties are characteristic of that classification.

SIGNATURES: I have reviewed this job description for content.

Reviewer's Name, Title & Position #: _____, #_____

_____ _____

Reviewer's Signature Date Reviewed

I have reviewed the content of the above job description with my supervisor.

_____ _____

Employee's Name and Signature Date

Attachment N

North Carolina Money Follows the Person Rebalancing Demonstration Preliminary Budget						
Demonstration Personnel						
	CY 2007	**CY 2008**	**CY 2009**	**CY 2010**	**CY 2011**	**TOTAL**
Project Director	$0	$59,428	$60,914	$62,437	$63,998	246,777
Program Specialist	$0	$59,428	$60,914	$62,437	$63,998	246,777
Admin Assistant	$0	$27,496	$28,183	$28,888	$29,610	114,177
Fringe Benefits	$0	$27,075	$27,752	$28,446	$29,157	112,430
TOTAL	$0	$173,427	$177,763	$182,208	$186,763	$702,161
Other Administrative						
MMIS Configuration	$1,000,000					$1,000,000
Total Administrative						$1,720,161

MFP DEMONSTRATION GRANT SUPPLEMENTAL BUDGET REQUEST INFORMATION

STATE NAME: North Carolina **AWARD NO. (Grant#):** 1LICM0030170

Attachment N1

SECTION A - BUDGET SUMMARY

Grant Program: MFP DEMONSTRATION Demonstration (a)	Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	State Match (d)	Federal (e)	State Match (f)	Total (g)
CY 2007 AWARD	$ 16,055.00	$13,206.84	$2,848.16			$16,055
CY 2008 REQUEST	$ 9,293,565.00			$13,635,512	($4,341,946.86)	$9,293,565
Total	$ 9,309,620.00					$9,309,620

SECTION B - BUDGET CATEGORIES

Object Class Categories	(1)	(2)	CY 08 Federal Funds (3)	CY 08 State Match Funds (4)	Total (5)
a. Personnel			$151,933	$151,933	$303,866
b. Fringe Benefits			$28,108	$28,108	$56,215
c. Travel			$10,000	$10,000	$20,000
d. Equipment			$5,000	$5,000	$10,000
e. Supplies			$3,369	$3,369	$6,738
f. Contractual			$0	$0	$0
g. Construction					
h. Service Dollars			$	$0	$0
i. Total Direct Charges *(sum of a-h)*			$198,410		$396,819
j. Indirect Charges (MMIS Configeration)			$1,330,969	$0	$1,330,969
k. TOTALS *(sum of i and j)*			**$1,529,379**	$198,410	$1,727,788

0.82% Special note: The total amount of the grant reward was adjusted by 55% ($9,293,565.00) due to the reduction of CAP/MRDD clients who are going to be transitioned.

NC Money Follows the Person Demonstration
Worksheet for Proposed Budget
ATTACHMENT N2

Instructions: Please fill in only the cells higlighted in YELLOW. All other cells will autopopulate. Please DO NOT alter any formulas.

State/Grantee:
NORTH CAROLINA
Grant #:
1LICMS030170
Demonstration Program Title:
NC Money Follows the Person

Please express FMAP as a decimal. (example: 68.32%=.6832)

	State FMAP	**Enhanced FMAP**
FFY 2007	0.6452	0.5
FFY 2008	0.6405	0.5
FFY 2009	0.6405	0.5
FFY 2010	0.6405	0.5
FFY 2011	0.6405	0.5

			FFY 2007	**FFY 2008**
State Name	North Carolina	**State FMAP***	0.6452	0.6405

Populations to be Transitioned (unduplicated count)

Unduplicated Count - Each individual is only counted once in the year that they physically transition.
All population counts and budget estimates are based on the *Calendar Year (CY)*.

	Elderly	**MR/DD**	**Physically Disabled**	**Mental Illness**	**Dual Diagnosis**
CY 2007	0	0	0	0	0
CY 2008	1	4	8	0	
CY 2009	5	22	51	0	0
CY 2010	7	30	61	0	0
CY 2011	9	24	82		0
Total Count	22	80	202	0	0
				Total of Populations	**304**

Demonstration Budget

Qualified HCBS Services, Demonstration HCBS Services and *Supplemental Services* are defined in the RFP.
Administration - Normal - costs that adhere to CFR Title 42, Section 433(b)(7);*Administrative - 75%* - costs that adhere to CFR Title 42, Sections 433(b)(4) and 433(b)(10);
Administrative - 90% - costs that adhere to CFR Title 42 Section 433(b)(3)
Federal Evaluation Supports - costs related to adminstering the Quality of Life Survey (reimbursed @ $100 per survey).

Rebalancing Fund is a calculation devised by CMS to estimate the amount of State savings attributed to the *Enhanced FMAP Rate* that could be reinvested into rebalancing benchmarks.

Other - Other costs reimbursed at a flat rate (to be determined by CMS)

Total Expenditures (2007 - 2011)	**Rate**	**Total Costs**	**Federal**	**State**
Qualified HCBS		$ 3,304,206.00	$ 1,652,103.00	$ 1,652,103.00
Demonstration HCBS		$ 957,956.00	$ 478,978.00	$ 478,978.00
Supplemental		$ -	$ -	$ -
Administrative - Normal		$ 656,331.00	$ 328,165.50	$ 328,165.50
Administrative - 75%		$ 1,182,208.00	$ 886,656.00	$ 295,552.00
Administrative - 90%		$ 16,055.00	$ 14,449.50	$ 1,605.50
Federal Evaluation Supports		$ -	$ -	$ -
Other		$ -	$ -	$ -
State Evaluation		$ -	$ -	$ -
Total		$ 6,116,756.00	$ 3,360,352.00	$ 2,756,404.00

Per Capita Service Costs	$ 14,020.27
Per Capita Admin Costs	6100.638158
Rebalancing Fund	$ 2,131,081.00

CY 2007	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.5	$ -	$ -	$ -	Actual Grant Award for CY	
Demonstration HCBS	0.5	$ -	$ -	$ -	Total Fed Costs	14449.5
Supplemental	0.6452	$ -	$ -	$ -	Balance	-14449.5
Administrative - Normal	0.5		$ -	$ -	Award Request for next year	
Administrative - 75%	0.75	$ -	$ -	$ -	Total (Balance + Request)	**-14449.5**
Administrative - 90%	0.9	$ 16,055.00	$ 14,449.50	$ 1,605.50		
Federal Evaluation Supports	1	$ -	$ -	$ -		
Other	1	$ -	$ -	$ -		
State Evaluation (if approved)	0.5	$ -	$ -	$ -		
Total		$ 16,055.00	$ 14,449.50	$ 1,605.50		

CY 2008	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.5	$ 53,044.00	$ 26,522.00	$ 26,522.00	Actual Grant Award for CY	
Demonstration HCBS	0.5	$ 45,597.00	$ 22,798.50	$ 22,798.50	Total Fed Costs	886202
Supplemental	0.6405		$ -	$ -	Balance	-886202
Administrative - Normal	0.5	$ 173,763.00	$ 86,881.50	$ 86,881.50	Award Request for next year	
Administrative - 75%	0.75	$ 1,000,000.00	$ 750,000.00	$ 250,000.00	Total (Balance + Request)	**-886202**
Administrative - 90%	0.9		$ -	$ -		
Federal Evaluation Supports	1		$ -	$ -		
Other	1		$ -	$ -		
State Evaluation (if approved)	0.5		$ -	$ -		
Total		$ 1,272,404.00	$ 886,202.00	$ 386,202.00		

CY 2009	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.5	$ 765,755.00	$ 382,877.50	$ 382,877.50	Actual Grant Award for CY	
Demonstration HCBS	0.5	$ 247,885.00	$ 123,942.50	$ 123,942.50	Total Fed Costs	595701.5
Supplemental	0.6405		$ -	$ -	Balance	-595701.5
Administrative - Normal	0.5	$ 177,763.00	$ 88,881.50	$ 88,881.50	Award Request for next year	
Administrative - 75%	0.75		$ -	$ -	Total (Balance + Request)	**-595701.5**
Administrative - 90%	0.9		$ -	$ -		
Federal Evaluation Supports	1		$ -	$ -		
Other	1		$ -	$ -		
State Evaluation (if approved)	0.5		$ -	$ -		
Total		$ 1,191,403.00	$ 595,701.50	$ 595,701.50		

CY 2010	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.5	$ 1,239,079.00	$ 619,539.50	$ 619,539.50	Actual Grant Award for CY	
Demonstration HCBS	0.5	$ 420,171.00	$ 210,085.50	$ 210,085.50	Total Fed Costs	1040623.5
Supplemental	0.6405		$ -	$ -	Balance	-1040623.5
Administrative - Normal	0.5	$ 148,685.00	$ 74,342.50	$ 74,342.50	Award Request for next year	
Administrative - 75%	0.75	$ 182,208.00	$ 136,656.00	$ 45,552.00	Total (Balance + Request)	**-1040623.5**
Administrative - 90%	0.9		$ -	$ -		
Federal Evaluation Supports	1		$ -	$ -		
Other	1		$ -	$ -		
State Evaluation (if approved)	0.5		$ -	$ -		
Total		$ 1,990,143.00	$ 1,040,623.50	$ 949,519.50		

CY 2011	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.5	$ 1,246,328.00	$ 623,164.00	$ 623,164.00	Actual Grant Award for CY	
Demonstration HCBS	0.5	$ 244,303.00	$ 122,151.50	$ 122,151.50	Total Fed Costs	823375.5
Supplemental	0.6405		$ -	$ -	Balance	-823375.5
Administrative - Normal	0.5	$ 156,120.00	$ 78,060.00	$ 78,060.00	Award Request for next year	
Administrative - 75%	0.75		$ -	$ -	Total (Balance + Request)	**-823375.5**
Administrative - 90%	0.9		$ -	$ -		
Federal Evaluation Supports	1		$ -	$ -		
Other	1		$ -	$ -		
State Evaluation (if approved)	0.5		$ -	$ -		
Total		$ 1,646,751.00	$ 823,375.50	$ 823,375.50		

Attachment O

List of Acronyms

Acronym	Full description
CMS	Center for Medicaid and Medicare Services
CAP/Choice	Community Alternatives Program/Choice
CAP/DA	Community Alternatives Program/Disabled Adults
CAP/MR-DD	Community Alternatives Program/Mentally Retarded/Developmentally Disabled
PACE	Program of All-Inclusive Care for the Elderly